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Draft Final Report

**“Exploring the synergy between promoting active participation in work
and in society and social, health and long-term care strategies”**

INVITATION TO TENDER N° 2006/030 (2006 / S 123-130484)

Contract reference VC/2006/0340

December 2007

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Foreword

The purpose of this study is to provide information that can help the Commission and EU Member States engage in policy discussion on how social, health and long-term care systems can help enhance participation in work and family, social and community activities and how, in turn, participation in paid employment, family, social and community activities can contribute to healthy and autonomous living at present and in the future.

Part I presents a review of the literature on the synergy between health and activity/work. Health affects work and social participation but on the other side work and activity affect health. We focus on people aged 55 and over as this interrelation (double causality) seems to be significant for important life events (retirement decision, social participation, etc.) of this age group.

Part II presents a quantitative analysis and tries to identify national specificities. It presents the lessons which we can draw from European surveys. It presents a quantitative analysis based on the LFS, the EU-SILC, the ECHP UDB and SHARE surveys.

The fourth step summarises national policies and gives a comparative analysis, while the fifth step presents the best practices.

Finally, the last part summarises the main conclusions and the policy implications.

DATA SOURCES

The statistical analysis is based on four sources of data:

- the special ad hoc module of the EU Labour Force Survey (LFS) on people with disabilities and long term health problems – carried out in 2002;
- the data collection of the EU Statistics on Incomes and Living Conditions (EU-SILC) carried out in 2004 and 2005;
- the ECHP UDB (notably Wave 8, 2001), and
- SHARE first wave, release 2, 2004.

The data concerning the LFS, the EU-SILC and the ECHP UDB were provided by the European Commission (Eurostat).

Country coverage of the surveys differs somewhat:

- the LFS covers all EU Member States except Latvia, Poland and Bulgaria and includes Norway;
- the EU-SILC covers EU Member States (except Malta) and also Iceland and Norway. However, the 2004 survey covers only 13 Member States – EU15 except Germany, the Netherlands and the United Kingdom, plus Estonia and also includes Norway;
- the ECHP UDB covers EU 15, and
- SHARE covers Belgium, France, Austria, The Netherlands, Spain, Italy, Sweden, Germany, Greece, Switzerland, Israel and Denmark.

The age of the sample varies according to the survey:

- The LFS Ad hoc module 2002 covers people from 16 to 64;
- The EU SILC and the ECHP UDB cover people from 16 and over;
- The SHARE covers people aged 50 and over.

The surveys also differ in terms of sample size and questions concerning health and chronic illness:

- sample size – the LFS being much larger than EU-SILC, SHARE or ECHP;
- questions on health status (very good, good, fair, bad, very bad) are covered in EU-SILC, in the ECHP UDB and SHARE but not in the LFS;
- The EU-SILC and SHARE presents whether a person “Suffer from any a chronic (long-standing) illness or condition”¹, while the LFS Ad hoc module focus on the “Existence of a long-standing health problem or disability”.
- EU-SILC and SHARE presents “Limitation in activities people usually do because of health problems for at least the last 6 months”². But the LFS Ad hoc module focus on ‘restrictions’ in terms of employment, (restrict the kind of work that can be done, restrict the amount of work that can be done, restrict mobility to and from work).
- The LFS Ad hoc module 2002 presents the “Type of health problem or disability” (15 different types).

¹ ECHP UDB: Do you have any chronic physical or mental health problem, illness or disability?

² ECHP UDB: Are you hampered in your daily activities by this physical or mental health problem, illness or disability?

Concerning activity and volunteering, the ECHP UDB puts the question “Are you a member of any club, such as sport or entertainment club, a local or neighbourhood group, a party etc?

About other kind of activities, SHARE asks which activities (not exclusive) do people did during the last month among: Voluntary or charity work; Caring for a sick or disabled adult; Providing help to family, friends and neighbours; Attending an educational or training course; Going to a sport, or a other kind of social club; Taking part in a religious organization; Taking part in a political or community-related organisation.

Share also asks people if they did moderate or vigorous physical activity during the last month.

As for long-term care, the ECHP UDB asks “Do your present daily activities include, without pay, looking after children or other persons who need special help because of old age, illness or disability? Share asks “In the last twelve months, have you personally given any kind of help to a family member from outside the household, a friend or neighbour? To whom? And what kind of help? ». The same question is asked for the help given inside the household.

Other specific methodological issues will be discussed in the relevant chapters.

PART I

Overview of existing work regarding the synergy between work and health

I.a Determinants of work participation and participation in family, social & community activities

I.a.1. Health and work

1.1 Introduction.

The EU has set the objective of raising the employment rate of older people. The European Council of Stockholm (2001) defined a target rate of 50% employment for workers aged 55 to 64 by 2010. Furthermore, the Barcelona European Council in March 2002 agreed on the target of gradually increasing the average retirement age by five years over the same period.

The Council and the Commission proposed to promote policies aimed at abolishing early retirement schemes, setting up more flexible working hours, and developing access to lifelong learning. The following review of the literature aims to see whether these proposals are feasible and to identify new methods which are compatible with (maintaining a good) the health status of the older workers.

Different generations of literature can be distinguished. The first generation uses subjective health measures and treats them as *exogenous variables*. The second generation treats health as an *endogenous variable* and uses objective health measures or instruments. A third group of literature overlaps previous groups and introduces dynamic aspects by analysing the effect of *health shocks*. In this section, we are going to present main empirical results obtained for the relation between health and labour supply of the elderly using these various approaches.

1.2 Overview and trends

In the early studies, health is thought to affect labour participation notably through two channels. The first approach considers health as a constraint (e.g. determined by genes). The second sees health as a choice (e.g. “investment” in health). In this perspective, A. M. Jones et al. (2005) note that if poorer health reduces life expectancy, then the annualised consumption available from existing wealth is raised, and this may lead to earlier retirement.

With data from SHARE, Kalwij et al. (2005) found that health is multidimensional. This means that different health indicators have their own significant impact on individuals’ participation decision. They realized a ranking of diseases with the criteria of its impacts on labour force participation.

A large pool of empirical studies have shown that health status is a determining variable for the whole labour force participation and therefore for the labour supply of older workers (Currie and Madrian, 1999). There is no consensus about the magnitude of the impact of health on retirement (Madrian and Currie 1999). Studies done in the US or more recently in Europe have produced different estimates depending on samples, time frames, and omitted variables biases of various types. But most researches find that, independently of the magnitude, poor health has a negative impact on labour participation.

Among the most important results, we can mention Gustman and Steinmeier’s estimates that showed that a serious health problem diminishes the retirement age by 4 years. Barnay (2005) for France, found that his health measure (reporting stop working for health reasons and reporting a disability period after the end of job) advance the retirement date for about 5 years. He also showed that

retirement for health reasons appears earlier for blue collar workers. Mental health has also been found having an impact on labour participation (Ettner et al, 1997).

Some papers compare the effects of financial variables and subjective health status on retirement. As Bound (1991) and Dwyer and Mitchell (1999), McGarry (2002) finds that the health variables effects are substantially stronger than the financial ones. It is however important to note that the comparability of the results is reduced because of the difference in samples, statistical methods and dependent variables.

1.3 Health as endogenous

The first group of studies on the relation between health and labour market trajectories uses self-reported health status or self reported work limitations. Currie and Madrian (1999) provide an extensive review of the empirical literature. The surveyed suggests that poor health reduces the capacity to work and has substantive effects on wages, labour force participation and job choice. The exact magnitudes, however, are sensitive to both the choice of health measures and to identification assumptions. These studies come to the conclusion that self reported health seems to be a major determinant of labour force participation when health treated as an exogenous variable.

Other studies and notably those using panel data try to deal with the endogeneity and measurement error issues and instrument self-reported measures using objective measures. Examples are Stern (1989) and Kreider (1996). We can mention another European study (Larsen, 2004), considering the effect of health on retirement plans of older workers drawn from a Danish panel survey from 1997-2002 merged to longitudinal register data. They use a wide array of alternative health measures and take into account of endogeneity and measurement errors. . These studies find that that self-rated physical and mental health appears to be important predictors of retirement planning, in fact more important than economic factors, both among men and women.

Dwyer and Mitchell (1999) in USA explain the expected age of retirement. They conclude that poor health is associated with earlier retirement plans. Functional limitations result in earlier expected retirement by one to two years. Self-rated health measures are not endogenously determined with labour supply and seem not to be correlated with compensation variables.

Retirement for health reasons appears earlier for blue collar workers because educated individuals systematically retire later; yet, the more educated individuals do not have higher lifetime employment rates (Vandenberg, V., 2005).

Kerkhofs et al. (1999) for the Netherlands use a competing risk model for employment duration to specify their retirement model empirically. Their approach concentrates on three alternative exit routes for the Netherlands: early retirement (ER), disability insurance (DI) and unemployment insurance (UI). They use different health measures and they are able to assess the effect of reporting errors and the endogeneity of health to retirement. They find that endogeneity is important in the case of ER and UI and that reporting errors are very important in the case of DI. Their final conclusion is that health is dominant in explaining transitions into DI and UI schemes. Financial incentives are the most important in the choice to apply for an ER scheme.

An important European paper that treats endogeneity problems by integrating work decisions, health production and health reporting mechanisms is that by Lindeboom and Kerkhofs (2002). With three equations (labour supply, health reporting and health production) they estimate three models with Dutch longitudinal data: (1) A model for work where financial incentives and health can affect retirement behaviour, (2) a health production model where current health levels can be affected by past labour market outcomes and (3) a model for health reporting behaviour that translates the observed subjective health index into a health that is free of reporting errors. This analysis shows strong effects of health on retirement and biased results of the labour force supply model when subjective measures of health are used. The direct use of a self-reported measure leads to exaggerated health effects in the

labour supply model. More interesting, their health production model reveals that increased work efforts eventually lead to a deterioration of health. This is important because it means that policy and social security reforms done to increase the labour force participation of the elderly may have an adverse effect on health.

1.4 Health shocks

Many researches have also looked at the dynamic aspect of health by using health shocks or change in health instead of health levels. Health shocks have been divided into three categories by McClellan (1998): (1) acute health events, (2) onset of a new chronic disease and (3) accidental injuries or falls. Anderson et al. (1986) and Bound et al. (1999) suggested that changes in labour market status should be associated with shocks to the individuals underlying health stock.

The Bound et al. (1999) US study does not only concentrate on labour force exit but considers three different transitions out of employment: labour force exit, job change and application for disability insurance. The main results of this kind of literature confirm that poor health is not the only factor that influences labour market outcomes, but change in health is also an important determinant for the elderly. Poor health leads many old workers to change their situation in the labour market. Among people in poor health more than half of those who exit the labour force apply for disability insurance. Among those who keep working many change jobs within several years of the onset of their poor health suggesting that changing jobs is an important way that older workers adapt to enable continued labour force participation. Moreover, the earlier a health shock occurs in their models, the less likely it is to lead to labour force exit.

The same approach of Bound et al. (1999) has also been used by Disney et al. (2003) for England. They showed that adverse individual health shocks are an important predictor of individual retirement behaviour. Deterioration in an individual's health is found to be strongly positively associated with movement out of work. Finally the authors found some evidence of asymmetry in the sense that a worsening health has a bigger impact on flowing into retirement than an improving health has on flowing out of retirement.

As noted above, M. Larsen and N. D. Gupta (2004) find that health is an important factor in retirement planning. In fact, health shocks seem to increase the propensity to retire earlier. They find that health effects are stronger for men than for women. According to Danø et al. (1999) one possible explanation of this gender difference is that men to a greater extent than women are employed in jobs that are inconsistent with poor health (e.g. jobs that require physical effort). A simple example is the high concentration of men in sectors like construction and manufacturing industries. Therefore, on the basis of their findings, the policy recommendation would be to expand preventive and neutralizing health care services. A particular effort should be directed toward preventing diseases such as osteoporosis, depression, back problems and myalgia.

The Finnish Centre for Pensions (2004) finds that a long work history and mental strain caused by the work are the most common reasons for plans to retire early (etk.fi). Persons who find that they are in good health are on average more interested in continuing to work after retirement age. Also highly-educated persons are interested in continuing to work, as are those whose spouse is still working. Of those who intended to retire before the age of 63 years almost every second person found that a deteriorating state of health was also an important reason for the plans to retire.

We can also mention that another European research (Jiménez-Martín S *et al.*) based on ECHP also found that the probability of keeping working decreases with both age and severity of the shock.

R. Riphahn finds that health shocks have a clear impact on subsequent labour force participation. In Germany, suffering a health shock increases the probability of dropping out of the labour force by 200 percent and drives up the unemployment risk by 90 percent. The negative effects of health shocks on household income and individual earnings are visible, particularly in the period following the event.

Women are most strongly affected by a drop in labour earnings. These households are addressed by government benefit programs, yet their effects do not balance the health shock related losses³. She concludes that there appears to be ample room for public policy initiatives to keep older workers in the labour force; possible measures are incentives for employers to accommodate health impaired workers or intensified use of medical rehabilitation programs.

Several empirical studies have shown that health status is a determining variable for the whole labour force participation and therefore for the labour supply of older workers (Currie and Madrian, 1999).

Certain studies⁴ find that health problems (functional limitations and circulatory disorders) influence retirement plans more strongly than do economic variables. Generally, men in poor overall health expected to retire one to two years earlier, an effect that persists after correcting for potential endogeneity of self-rated health problems. This means that extending working life without taking into account health might increase their health problems.

1.5 Health and wealth

The conclusion that health problems might advance retirement has been contested by some critics. M. S. Miah and V. Wilcox-Gök (2005) use retrospective data from the US Health and Retirement Study (HRS). They find that chronic illness leads people with an early chronic illness to accumulate fewer assets during their working years and consequently retire later. In contrast, a working person who suffers the onset of a disabling disease toward the end of his/her career has had more opportunity to build a larger portfolio of retirement assets than his/her chronically ill counterpart and may retire from the labour force earlier, other things equal. Both individuals have poor health at retirement age, which increases the probability of retirement, other things equal. However, the individual with long-term illness will have lower expected asset income, which decreases the probability of retirement. Thus, chronic illness may have two opposing effects on labour supply. This means that the most vulnerable (with very long chronic illness) will be incited to stay on the labour market despite their bad health. This in turn may further decrease their health. However, this effect might be attenuated in European countries with well developed social protection systems for people with long-term illness.

1.6 Health and absenteeism

There is an ongoing discussion on the relation between health and absenteeism of older workers. Though research results show a negative relationship between health and absenteeism they present mixed results for age. In fact, it is difficult to estimate the proportion of absenteeism assigned to health and the proportion due to age.

When workers do not freely choose working hours and should accept a more or less 'rigid' organization of working time, absenteeism is a means to adapt effective working hours to the individuals' optimum. Since bad health, chronic illness and disabilities affect the distribution of the time budget, people with health problems and chronic illnesses will be more prone to absenteeism than the rest of the population. C. García-Serrano and M. A. Malo (2006) using data from the European Community Household Panel for Spain, investigates the influence of disability on absenteeism reported by workers. Results show that workers with disabilities are more likely to fail to turn up to work than workers without disabilities. This finding holds even when individual's self-reported health, visits to the doctor and nights at hospital are included in the estimations.

G. Krul and J. Moester find that workers with a disability or chronic illness in the Netherlands and people who have returned to work after a period of disability or illness report in sick more often than average. The group receiving and formerly receiving a disability benefit comprises more older employees than the total group of employees. After correction for this difference, sickness absence

³ R. Riphahn (1998).

⁴ Debra Sabatini Dwyer and Olivia S. Mitchell, (1999).

falls by about half of a percent point. The higher absence rates are therefore hardly explained by the age composition of the group. Similarly, the Danish employers (E. E. Simonsen, 2006) find that workplace absenteeism is lower for older workers than for their younger colleagues.

It is important to note that the rate of absenteeism depends on the general economic situation. This means that comparisons across countries ought to take into account the different economic situations. In fact, Grignon et Renaud (2007) show a negative correlation between the number of days in absenteeism and the unemployment rate in France over the last thirty five years (what confirms the economic literature which makes of the absenteeism a "procyclic" phenomenon). This observation can suggest the existence of rational behaviour on behalf of the employees who, in period of weak unemployment, are less afraid of being dismissed or penalized (in their salary or their promotion) and can so use absenteeism as the factor of adjustment in their choice between work and leisure.

Surveys report that although sickness absence among older workers is not higher than absence among younger workers, the average duration of sickness is longer⁵.

It is interesting to note two studies concerning the Netherlands and Sweden. These countries experience high rates of absenteeism for older workers.

D. Andrén analyses the Swedish case and suggests policies to prevent and slow down the increasing trend of long-term sickness of those in older age-groups. He argues that these policies ought to relate both to working conditions and to health problems related to work. One such policy would be greater flexibility in working time. Also, they ought to prevent deterioration of health status of younger employees.

M. De Graaf-Zijl *et al.*⁶ study absenteeism in the Netherlands. They find that the following interventions are efficient in reducing absenteeism: accelerated checks when shirking is suspected, risk assessment of working conditions and appointment of a labour conditions coordinator.

Consequently, policies to keep people with chronic illness in the labour force require consequently an adaptation of laws and policies concerning absenteeism of older workers.

R. Osterkamp and O. Röhn⁷ study differences across 20 industrialised countries of sick leave days per employee. They argue that the generosity of granting sick leave, the strictness of employment protection and the employment of older persons are the main explanatory factors.

Certain researchers note that countries with high rates of sickness and disability benefits (e.g. Sweden⁸, Netherlands and Finland) have also the highest proportion of people who present own illness, injury or temporary disability as a reason for not having worked at all though having a job.

1.7 Conclusions

There is a bulk of evidence that shows that health status is a determining variable for labour force participation in general and therefore for the labour supply of older workers. Even if there is no consensus about the magnitude of health effect relatively to other variables on labour force outcomes, it is clear now that the health factor play an important role in labour participation and retirement models. Consequently, poor health and changes in health i.e. a deterioration in health (physical and mental) lead to:

- moving out of the labour market

⁵ <http://www.eurofound.europa.eu/areas/populationandsociety/cases/nl016.htm>

⁶ M. de Graaf-Zijl, J.P. Hop and L.M. Kok, (2005).

⁷ Rigmar Osterkamp and Oliver Röhn, (2007).

⁸ For Sweden see: 1) Daniela Andrén, (2003)

- early retirement
- unemployment and longer unemployment spells
- higher absenteeism
- disability insurance
- low job satisfaction

The impact of health may be immediate but certain effects may be distributed through the life cycle.

I.a.2. Financial (dis)incentives and work

2.1. Introduction

Labour force participation of older workers has fallen over the past three decades in most countries. Consequently, it is interesting to study the different factors which might explain these changes.

The first section will study the impact of social security provisions on early retirement. The second section will analyse how certain countries apply earnings tests in the provision of pension benefits. The third section will discuss the relation between early retirement and invalidity pensions.

2.2. Pension incentives

Labour force participation of older workers has fallen in most countries. An explanation is that social security provisions themselves provide incentive to leave the labour market early. Concerning the retirement age issue, we must pay attention to the important role that financial incentives can play. To illustrate this issue, we can mention the Gruber and Wise's studies (1999, 2004). In two volumes (and a third one coming soon), they analyze pension incentives and their impact on retirement behavior in various countries. National research teams were able to draw a quite precise description of pension incentives in each country and their impact on retirement.

In their first volume of "Social Security and Retirement around the World", Gruber and Wise presented an overview of the provisions of social security plans in eleven countries⁹ that can create large retirement incentives. They present evidence on how these incentives appear to be reflected in retirement behaviour.

Two features of social security plans have an important effect on labor force participation incentives. The first one is the *early retirement age*, which is the age at which benefits are first available. The second one is the *pattern of benefit accrual*. This concept calls for a little explanation. Suppose that, at a given age, a person has acquired entitlement to future benefits on retirement. The present discounted value of these benefits is the person's Social Security Wealth at that age. The key consideration for retirement decisions is how this wealth will evolve with continued work. The difference between Social Security Wealth if retirement is at age a , and Social Security Wealth if retirement is at age $a+1$ is called social Security Wealth Accruals. Gruber and Wise compare the retro of Social Security Wealth Accruals to net wage earnings over the year. If the accrual is positive, it adds to total compensation from working the additional year; if the accrual is negative, it reduces total compensation. A negative accrual discourages continuation in the labour force and a positive accrual encourages continued labour force participation. The pension accrual is typically negative at older ages. Continuation in the labour force means a loss in the present value of net pension benefits, which impose an implicit tax on work and provides an incentive to leave the labour force.

The importance of social security wealth accrual and the corresponding tax or subsidy differ greatly from country to country and are determined by several provisions. The most important determinant of accrual is the adjustment to benefits if a person works another year. The greater the adjustment is, the greater the inducement to continue working. Second, a person who continues to work has to pay taxes on earning which lower the net accrual. Third, the last year of work is often used to recompute Social Security benefits, which can raise net accrual if we assume that earning in late life are greater. And

⁹ Analyses were done for Belgium, Canada, France, Germany, Italy, Japan, the Netherlands, Spain, Sweden, United Kingdom, and United States.

finally, net accrual may be lowered because a delay in receiving benefits raises odds that the worker might die before being able to collect any benefits.

We also have to mention that other government programs (unemployment and disability insurance) and private programs (e.g. employer-provided pension plans) may also affect the relation between Social Security plan provisions and observed retirement patterns.

At the end of the first volume, Gruber and Wise (1999) extracted three important conclusions from the data. First, there is a strong correspondence between early and normal retirement ages and departure from the labour force. Second, the social security provisions in most countries place a heavy tax burden on work past the age of early retirement eligibility and thus provide a strong incentive to withdraw from the labour force early. Third, the tax -and thus the incentive to leave the labour force- varies substantially among countries. So does retirement behaviour.

In the second wave of their study, Gruber and Wise (2004) analyzed country by country with micro-data retirement behaviour. For each country¹⁰, econometric estimation of retirement models was done. Their goal was to estimate how much the retirement age was influenced by Social Security provisions. They found strong confirmation of the causal relationship between retirement and Social Security. The results showed the enormous effect of Social Security incentives on retirement, and the uniformity of findings is striking. In every country, the quantitative magnitude of incentive-program effects on retirement is very large. The national microeconomic regressions use generally the probability to prolong activity (dependent variable) to social security wealth, incentive variable, projected earnings and age dummies. Social security wealth has a negative impact while projected earnings have a positive impact¹¹. The impact is larger in countries such as Belgium, France and Italy known for their low rate of activity at old age than in countries such as Sweden and Japan. Also the exit routes vary across countries: e.g. France and Belgium use early retirement schemes and unemployment insurance whereas the Netherlands for long has used disability insurance. Social Security retirement incentives have very similar effects on labour force participation in all countries. This confirms that the differences in labour force participation across countries are not the result of cultural differences among countries that could yield different norms for work at older age but are largely related to institutional/ financial incentives.

Research teams in each country then simulated a reform that reduces retirement incentives in some countries and increases incentives in other countries. Simulations show a large reduction in retirement in each country, and a corresponding increase in the labour force participation of older workers. Considering the average across all countries, a reform that delays benefit eligibility by three years would likely reduce the proportion of men aged fifty-six to sixty-five out of the labour force between 23 and 36 percent in the long run. The findings thus confirm the conclusions of the first volume of Gruber and Wise's research.

All these results leave no doubt that Social Security incentives have a strong effect on retirement decisions, and the estimates show that the effect is similar in countries with very different cultural histories, labour market institutions, and other social characteristics. This proves the role of social security reforms in labour force rates of older workers.

At about the same time, as the first wave of Gruber and Wise came out, Blondal and Scarpetta (1998) from the OECD published a paper in which they were explaining the falling participation rates among older workers by the disincentive role of social security systems. This study encompasses 22 OECD member countries and considers, not only pension systems, but also other non employment benefit systems. Their conclusion is similar to that of Gruber and Wise (1999): social security depresses activity in old age and this accounts for wide variation in the age of effective retirement.

¹⁰ Analyses were done for the same eleven countries that in the first volume and also for Denmark.

¹¹ A first regression relates the activity rate (dependent variable) to the tax force (implicit taxation on prolonged activity).

In a review of pension reforms in the European Union, the authors find that the NDC (Notional Defined Contributions) has clear merits, notably it constitutes an incentive for later retirement (Oksanen, 2004).

2.3 Earnings tests

In a number of countries pension benefits are subject to earnings tests. In short this means that an individual whose earnings exceed a certain ceiling faces a reduction in pension benefits.

Some countries do not have such test. Other have them but in variable forms. The rules, that are ceilings and withdrawal rates, vary significantly across countries and over years. They also vary according the type of pension benefits and the age of the beneficiary.¹²

If we include disability and unemployment insurance in the early retirement schemes the earnings test picture becomes even more complicated.

In a kernel, earnings tests tend to be prohibitive for early retirees who draw benefits from unemployment or disability insurance. They are harsh for workers who stop working through early retirement schemes. They are lighter and often inexistent for "standard" retirees, namely those who retire after the normal age of retirement.

In this section, we first present the standard arguments in favour and against earnings tests. Then we give the earnings test rules of some European countries.

Here we focus on earnings tests applied to pension benefits. It is however worthed to analyze the pros and cons of earnings tests in other types of social insurance and social assistance and even in private insurance. Table II.2 lists a number of schemes where earnings tests could apply.

Table I.1: Earnings tests in alternative insurance schemes

	Public	Private	Earnings tests
Assistance to the poor	v		Total
Disability/sickness replacement income	v		Total
Disability/sickness replacement income		v	Total
Early retirement schemes	v		Important
Unemployment insurance	v		Total
Pension	v		Variable
Pension		v	Nil

In case of compensations because of poverty, one generally considers earnings tests as desirable. The idea is that public money is scarce and compensations are means tested. Some arrangement can be found in case of transition towards partial or full time employment.

In case of insurance for sickness or disability, both private and public sectors tend to impose strict earnings tests. They are in the spirit of what an insurance means: it compensates the insurees against the risk of an income loss. If there is labour income, there is no reason for compensation. The same argument holds for unemployment insurance that is always public.

¹² In the US before 2000, benefits above the annual exempt were subject to a 50% tax for those below 65, to a 33% tax for those between 65 and 70 and to no tax for those above 70.

Early retirement schemes can be motivated by two different concerns: provide a transition replacement income for an elderly worker who loses his job and will not find another one before the regular age of retirement or get rid of workers who have become costly relative to their productivity. In general earnings tests apply except in occupation where the early retiree is clearly in good health and able to start a new career. This is the case of army jobs, e.g..

One of the *raison d'être* of earnings tests in early retirement schemes is the fear that early retirees will take the jobs of other workers who should have the priority: typically young workers particularly in countries where youth unemployment is high. This idea that preventing elderly workers from working fosters the employment of the young is as widespread as ill-founded. It is known as "the lump of labour fallacy" and rests on the postulate that the labour market is a zero-sum game.

One finds the same argument behind earnings tests for regular pensions. There are two other arguments. One is redistributive. Cremer *et al.* (2007) have shown that some earnings tests might be desirable in some cases. They introduce the idea of a second career that would start after the official retirement age. The question is whether or not earnings coming from such a second career ought to be more taxed than those of the primary career. They show that this is the case when heterogeneities in health and wages are more significant after official retirement than before.

Another argument in favor of earnings tests applies when the pension system is Beveridgean, namely when there are no links between contributions and benefits. Benefits don't come from previous savings, but from social solidarity. Such solidarity could vanish if those pensioners had other sources of income.

2.4 Actuarial fairness and alternative retirement paths

There is a large debate on whether incapacity may become one of the main reasons for early retirement. This might be strengthened in a context of confusion between the roles of sickness insurance, incapacity insurance and unemployment benefits. National situations are different.

Many empirical studies have attempted to measure the redistributive effects of the pay-as-you-go system using the concept of actuarial fairness. This concept refers to a situation of equality between the present value of pension benefits and the present value of pension contributions during the life cycle. The social redistribution observed most frequently is from the poorer classes towards the better-off classes (Lagarde, 1985, in the UK: Creedy *and al.*, (1993), S. Grammenos *et al.* (2005)).

Barnay (2007) shows that the application of actuarial fairness in France ought to lead to a noticeable difference in the retirement age by social category in order to compensate for these mortality differences. Applying the concept of actuarial fairness leads to substantial differences in age at retirement by SPC, given the difference of 6 years between unskilled workers and executives for men retiring above the age of 55 with a single pension from the private sector and no interruption to their payment career.

R. T. Riphahn analyses the determinants of disability retirement and unemployment of older workers, two labour market phenomena which the German public discussion combines under the label of early retirement. The implicit assumption that these two mechanisms are exchangeable pathways into permanent retirement is tested. Using panel data the transition rates from employment into disability retirement and into unemployment are estimated and compared. Statistical tests reject the hypothesis that disability retirement and unemployment are substitutes¹³. In another study she finds that a benefit reduction would be largely ineffective in reducing the level of disability retirement in Germany¹⁴.

¹³ R. Riphahn (1997)

¹⁴ R. Riphahn (1999)

In the same direction, T. Hakola studies the Finnish retirement behaviour. The results indicate that health is not only a very strong determinant to direct people to the disability channel, but it also diminishes the likelihood to follow the other labour force withdrawal routes – most notably the unemployment route¹⁵.

On the contrary, for the Netherlands, Kerkhof et al. find that there is evidence that income streams in alternative exit routes are compared in the retirement decision and that alternative exit routes act as substitutes¹⁶. Recent reforms have reduced access to disability benefits (e.g. the Netherlands).

In the United Kingdom, employment rate of seniors has increased significantly since 1997. In spite of weak generous disability allowances, the recourse to these pensions has increased for people aged 60 years or less. It is not thus enough to make less generous disability pensions to increase employment rate of seniors. In most of the countries, the reduction of all the ways of premature exit from the labour market (unemployment and disability in particular) with a financial valuation of the pursuit of professional activity, in a context of high economic growth, leads to higher employment rates for seniors.

To explain the premature departure from the labour force, the economists use the concept of implicit tax on any continuation of the activity. Many studies describe the impact of Social Security, employee benefits, and the tax system on the financial incentive to work for employees aged 55 and older (Coile and Gruber, 2004). Butrica and al. (2006) also take into account Medicare and show that the implicit tax rate on work increases quickly and nearly doubling between age 55 and 64 in the male population in the USA. According to Duval (2003), the average tax rate across 22 OECD countries is less than 5% (10% excluding France and Luxembourg) at age 55 while it is above 30% at ages 60 and 65.

Concerning age retirement, there is not a general agreement that simply raising the earliest eligibility age is an efficient solution. Opponents claim that many individuals can neither work longer nor save more for retirement. Raising the earliest eligibility age could impoverish these groups as well as strain social programs like disability benefits that would likely end up serving more people. Finally, they contend that withholding benefits until a later age hurts those with shorter life expectancies, and shifts more retirement wealth to those with longer lives¹⁷.

Withholding Social Security benefits until age 65 would hurt those with shorter life expectancies, and these people tend to be low skilled males. Any increase ought to take into account work penibility and life expectancy. Furthermore, a higher legal retirement age might result in a decline of old age pension as an incentive to work longer. This will further discriminate against low skilled manual workers.

2.5. Conclusions

The different studies indicate that the low labour participation of older workers raises a certain number of issues, notably:

- The quantitative magnitude of incentive-program effects on retirement is large. Differences in labour force participation across countries are not the result of cultural differences.
- Social security provisions in most countries place a heavy tax burden on work past the age of early retirement eligibility and thus provide a strong incentive to withdraw from the labour force early. Implicit tax on any continuation of the activity is very high for persons aged 60 to 65.

¹⁵ T. Hakola

¹⁶ M. Kerkhofs, *et al.* (1998).

¹⁷ Alicia Munnell, (2006)

- Financial incentives to early retirement should be abandoned so as to make the overall pension system neutral towards retirement decisions.
- In case of non-contributory compensation because of poverty, earnings tests are desirable. Public money is scarce and compensations are to be means tested.
- In case of insurance for sickness or disability, both private and public sectors tend to impose strict earnings tests. So doing, it is crucial to keep open the possibility for workers with frail health to retire through disability insurance.
- Disability and unemployment are mechanisms which might be exchangeable pathways into permanent retirement in certain countries.
- Actuarial fairness requires the revision of certain schemes. There is a social redistribution from the poorer classes towards the better-off classes. Mortality differences have to be taken into account.

I.a.3. Family status and work

3.1 Introduction

A growing literature on the joint labour supply behaviour of husbands and wives examines how married couples coordinate retirement decisions. These studies have shown that spouses often retire at about the same time as each other. The “joint retirement”, that is, the husband and wife exiting the labour force at approximately the same time, has become an important issue in many retirement studies.

Several reasons can justify the existence of joint retirement. First, there could be observable economic factors affecting both members of the couple and causing a positive correlation between retirement dates. Second, poor health or chronic illness may influence not only individual own retirement but may increase the necessity of care giving and, consequently, influence spouses retirement behaviour. Also unobservable factors highly correlated between husbands and wives (assortative mating) could originate such a correlation. Finally, strong complementarities between the husband and wife’s leisure time would explain why couples tend to retire at the same time.

3.2 The concept of “joint retirement”

Joint retirement outcomes appear to be driven in large part by the widespread preference of husbands and wives to spend their leisure time together. Economists typically model labour supply decisions by assuming that individuals strike an optimal balance between the costs of foregone leisure and the benefits of increased income associated with paid employment. If married individuals place greater value on leisure time when they can spend it with their spouses, then retirement rates will increase when the spouse is not working.

The results of models estimated by Gustman and Steinmeier (2000) and Hurd (1988) support the hypothesis that individuals view their own leisure time and the leisure time of the spouse as complements.

Coile’s (2003) findings are also consistent with this hypothesis. She found that retirement rates in the Health and Retirement Study (US) responded to own financial incentives created by employer-provided pension plans and Social Security and by “spillover effects” from the spouses’ incentives. Spillover effects are possible due to income effects and complementarity of leisure. Coile attributed the existence of spillover effects to efforts by spouses to coordinate their retirement decisions. Financial incentives created by retirement plans affect the worker’s retirement decisions, which in turn affect the behaviour of the spouse.

Less empirical support has been found for other possible explanations of joint retirement, such as assortative mating and the similarity of financial incentives faced by husbands and wives. Individuals may tend to marry those who share similar preferences about work and leisure. As a result, the timing of retirement may coincide for husbands and wives because of assortative mating, not because husbands and wives carefully coordinate work and leisure activities. Gustman and Steinmeier (2000) also concluded that financial incentives cannot account for joint retirement outcomes.

Sociologists have focused on a different set of determinants than economists. The factors that they have emphasized include norms, features of individuals’ family and career trajectories (including the history of role occupancy earlier in the life course), social aspects of transitions to new roles, and gender role attitudes. Henretta et al. (1993) examine the linkage of couples’ late-life work exit patterns with earlier work and family roles. With US data, they estimate a sequential model of retirement timing of husbands and wives. Indeed research based on the life-course perspective establishes the

importance of the link between early and later events, with early events conditioning the pathway through later events. The results indicate that early investments in work and family roles, as well as late-life characteristics, are associated with how older couples coordinate retirement timing. A woman's employment during the child-rearing years is associated with her earlier retirement especially following her husband's retirement. The findings reveal the importance of the early "family organizational economy" in defining sequences of family events that combine with late-life events to influence the sequential synchronization of retirement timing.

The determinants of retirement also appear to differ for husbands and wives. For example, several studies have found that family issues and roles are more important for wives than for husbands. At the same time, men appear more likely than women to withdraw from the labour force in order to spend more time with their spouses (Gustman and Steinmeier 2000; Coile 2000).

We have to note that men and women do not have the same attitude toward retirement. Russel Hatch L. (1992) studied differences in retirement behaviour between men and women. Her article concludes that differences in women's and men's occupational and economic circumstances are responsible in part for gender differences reported in the retirement literature, but in addition, marital circumstances also exert an important influence. In deed, structural conditions, such as social resources, health, income, or length of labour force participation rather than gender differences per se have been evoked ex post facto to explain the observed differences. Compared to men, women have often briefer, less continuous patterns of labour force participation. As a consequence, women may be vulnerable to economic losses associated with retirement. This article found that previously married women, who often face a poor financial situation in retirement, were less likely than previously married men to agree that older workers should retire and also less likely to define themselves as retirees.

3.3 Evidence on "joint retirement"

Timing of retirement in dual worker families is of increasing importance because of the large number of women now in the labour force. In the past, the retirement of the husband was a signal to a major change in the family. But now, the relative age of retirement of both spouses define variant family patterns. Division of household work, leisure time pattern and retirement satisfaction are likely to be different depending on whether and why two spouses retire together or alone.

Before looking at the literature review, we have to mention that measurement of joint retirement is somewhat arbitrary since it depends on the definition of "retirement" and the definition of "joint". Results depend on variables taken into account. Retirement could be partial or not. Joint retirement is not only retirement that happened for both spouse in the same year. Some authors also called joint retirement spouses who have retired in a three years period.

The first research about this joint decision of retirement in dual worker family is done by Henretta et al. (1983). In this paper, three patterns in family retirement were distinguished: (1) *joint retirement* in which both spouse retire at the same time; (2) *substitute retirement*, a pattern in which the wife works after the husband; (3) *secondary retirement*, a pattern in which the husband works longer than the wife. All these patterns assume that workers approach retirement as an individual decision made with respective work and earning histories. But, the final pattern of retirement of the couple cannot be understood without defining the relation to each other of couples' work and related pre-retirement attributes. The longitudinal data from the US Social Security Longitudinal Retirement History study shows that both spouse' characteristics affect retirement timing. Husband's and wife's age, hourly wage and pension coverage have parallel, symmetric effect on the retirement pattern chosen. In deed, the older one spouse, the more likely the couple will follow the joint pattern instead of the partner in which that spouse works longer. The lower the wage of one spouse, the more likely is the couple to follow the pattern in which the other spouse works longer. Lack of pension coverage is associated with the pattern in which the spouse without a pension works longer, instead of the joint pattern. They also found a predominant role of husband's work (secondary retirement) if the husband has no health limitation, if social security benefits are low and if there is support for a child.

Hurd (1998) using US data, both simple data analysis and economic models of the age of retirement, points to the coordination of retirement dates: husbands and wives tend to retire at the same time. According to the results, very little of the coordination is due to economic variables, and simple cross-tabulations rules out assortative mating as an important explanation. This leaves complementarity of leisure. Because of data limitations, this conclusion is, however, mainly qualitative.

Blau (1999) modelled the labour force behaviour of older married couples in Germany. He estimates a discrete time, competing risks hazard model of transitions among labour force states defined by the employment status of both spouses. The analysis indicates that the probability of one spouse exiting employment is much larger if the other spouse is not employed than if the other spouse is employed. Similarly, one member of a couple is much more likely to enter employment if the spouse is employed than if the spouse is not employed. The findings indicate a strong propensity among couples to spend leisure time together.

Blau (1998) estimated that between 30 and 40 percent of married couples, exited the labour force within a year of each other, depending on the exact definition of retirement he used. Among German couples in which both spouses have a long-term attachment to the labour force, 10% of husbands and wives exit the labour force in the same year and 40% within 3 years of each other. This is quite similar to patterns found in the US (Hurd, 1990-1998; Blau, 1998.) In deed, Hurd (1988) found that about one quarter of couples in the New Beneficiary Survey (NBS) retired within a year of each other and a significant percentage (between 6 and 9 percent) retired in the same month. Taken together, these studies indicate that in many couples, husbands and wives retire at about the same time, although the proportion appears to be declining over time.

With data from the European Community Household Panel (ECHP), Jimenez-Martin et al. (1999) studied the dynamics of joint labour force behaviour of older couples for the EU12 countries. Their results showed a strong evidence of complementary, but asymmetric, effects between the labour supply decisions of both spouses. It seems that the husband's decision affects more his wife's decision than vice versa, whatever the origin state of the spouse. According to their results, a working spouse is more likely to retire the more recently the other spouse has retired; this effect is stronger if the wife is the working spouse. They had evidence of assortative mating and/or complementarities in leisure; the effects of all relevant factors on the retirement decision of one spouse depend strongly on whether the other one is working, unemployed, or retired. Besides the standard evidence that poor health increases the retirement probability, they found that the husband's health affects the couple's retirement decisions much more strongly than the wife's health does. Additional asymmetric effects are detected with respect to income related variables.

To understand better what is behind joint retirement decision, Smith et al. (1998) examine husbands' and wives' perceptions of spousal influence on the decision to retire. Their study reveals that retirees and their spouse agree that spouses do influence the retirement decision, but spouse view their role as more minor than the retirees, themselves, see it. Their results on individual perception for retired husbands and their wives suggest that retired husbands see their wives as having more influence on their retirement decision than the wives, themselves, report. Retired wives' perceptions of the level of their husbands' influence on their retirement decision is, on average higher than their husbands' own reported assessment. Couple differences regarding perceptions of spousal influence are more pronounced when the retiree is a man rather than a woman. This study provides evidence that retirees' spouse do influence the retirement decision, although the factors associated with spousal influence differ by the gender of the retiree.

3.4 The role of partner's health

Even if a major part of the literature focus on the individual, some papers take into account the health of other family members like children, parents but especially spouses. Family labour supply models

are done. Behaviour is determined by the maximization of a single utility function subject to a family budget constraint in which income is pooled and the allocation of consumption between the spouses is not modelled.

Many authors have studied the “joint retirement” issue¹⁸, coming to the conclusion that having a retired spouse increases the probability of retirement, but they did not pay attention to spouse’s health. If a worker with health problems retires at a relatively early age, the spouse may remain at work (or enter the labour force if not currently employed) to compensate the loss in family income. Alternatively, the healthy spouse may choose to work fewer hours in order to devote time to the care of the frail partner. Thus, the simultaneity in spousal retirement behaviour may depend critically upon health status.

The ability to delay retirement can provide insurance against the loss of family earnings that often results when spouses develop serious health problems. The other possibility for the healthy spouse is to withdraw from the labour force to provide personal care assistance when their spouses become disabled. In this case, the onset of disability can have especially serious financial repercussions for families.

Johnson et al. (2001) worked on this particular issue. They analyse the retirement decisions of married couples in the United States and how they interact with spousal health and employment using the first 3 waves (1992-1996) of the HRS. They concluded that the employment and health status of the spouse appear to have important effects on retirement decisions for married women and men. Their study underlines the importance of marriage in providing insurance for those who become disabled.

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In the same couple approach, Blau and Riphahn, 1999, analyse labour force transitions of older married couples in West Germany. They found that individuals with a chronic health condition are less likely to stay employed and more likely to exit the labour force. Wives are less likely to exit the labour force and more likely to enter the labour force if the husband has a chronic condition and is still working, and are in contrast more likely to exit and less likely to enter if the husband has left the labour force for health reasons. The same pattern does not hold for men (evidence of asymmetries). Husbands are less likely to stop employment and less likely to re-enter employment if the wife has a health condition, a response that is independent of the wife’s labour force status.

¹⁸ We will introduce joint retirement in the following.

Jimenez Martin et al. (1999) use data from the European Community Household Panel (ECHP). They describe and analyse the dynamics of joint labour force behaviour of older couples for the EU12 countries. They found some evidence of the joint retirement decision, but especially on health, they found that the husband's health affects the couple's retirement decisions much more strongly than the wife's health does. This means that illness of the husband tend to accelerate more the retirement of the couple than the illness of the wife does.

Finally, the important couple approach analysis of Coile (2003) for the US measures the effect of each spouse's health events on the other spouse's labour supply (hours and participation). It is the first paper that combines a broad range of health variables and a couple-approach. Major findings of the paper are that health shocks have an important effect on own retirement. In the sample as a whole health shocks have no significant effect on the spouse's retirement either for men or women. There is also evidence of substantial crowding out of spousal labour supply by disability insurance benefits.

3.5 Conclusions

The results from the studies devoted to joint retirement share a number of common conclusions. The findings call for consideration of the added dimension of joint couple behaviour in the ongoing regulatory reforms of the retirement system in industrialized countries.

Such reforms ought to take into account the following aspects:

- There is a trend for couples to retire approximately at the same time. Retirement age should be more flexible upward.
- The harmonisation across gender ought not to imply a uniform age threshold across occupations. Life expectancy ought also to be taken into account. In fact, heavy and dangerous occupations might require lower retirement thresholds.
- Reforms might have a bigger impact if they take into account the fact that retirement might be a joint decision inside a couple.
- The employment and health status of the spouse appear to have important effects on retirement decisions for married women and men.
- Illness of the husband tend to accelerate more the retirement of the couple than the illness of the wife does.
- Marriage in providing insurance for those who become disabled.

I.a.4. Long-term care and work

4.1 Introduction

Long-term care is different from traditional health care as it provides “assistance in activities of daily living to people not able to complete them due to disability”¹⁹ and is not a short term intervention to improve people’s health. Main goals of old age policies – containing long-term care policies - are (1) the promotion of autonomy and (2) prevention of dependency.²⁰ Even though the general health conditions of the elderly improved in the last years the need for long term care is increasing as the number of people of very old age is rising as well and disabilities at least in the last part of life are a biological reality.

Providing long term care might be an important factor determining labour participation of carers. Consequently, it is interesting to analyse how it is organised.

4.2 Social care models

To better understand the different long-term care policies of the European member states it is useful to have a look at their general approach of organising their social care systems. Social care models in Europe (EU) (including long-term care) can be summed up into three categories.²¹

- (1) the state responsibility model,
- (2) the family care model and
- (3) the subsidiary model.

The state responsibility model is characteristic for the Scandinavian countries and the UK. The state or local governments are mainly responsible for the provision of social services which are universal and widely available but in the UK where means-testing assures that the services are allocated to less wealthy people. Family care is rather uncommon, as professional services are provided. At first sight, this model ought to favour labour participation as carers are assisted by public services.

In countries where the family care model is dominant (Portugal, Spain, Greece, Italy) the family is the main provider of social care and the state only provides very modest services. This fosters not only informal care but also services provided by the grey market. Only wealthier people are able to use the privately paid commercial services. After transformation most central eastern countries can be also allocated under this model. This model might constitute an obstacle in the labour force participation of carers.

The central European subsidiary model (Netherlands, Germany, Belgium, and France) relies on the family as the primary responsible caretaker of the elderly with intermediate organisations providing services which can replace informal care when necessary.

“Since the beginning of the 1990s social care approaches have been characterised by an increasing marketisation,²² i.e. a withdrawal of the state from service delivering, and corresponding efforts to establish fair access to the services for all citizens as well as an increasing recognition and support of informal family care”²³

¹⁹ Grammenos et al. 2005

²⁰ Gibson 1998, after Theobald 2005

²¹ Anttonen und Sipilä after Theobald 2005.

²² Ranci and Pavolini 2004

²³ Theobald 2005

With the move to market liberalisation “cash benefits” as opposed to services are becoming increasingly common in the redesign of long-term care policies and can be seen as a major trend in the area of social care.²⁴ Through this system the person in need of care is provided with cash she or he can spend freely to cover their needs of care. This practice is introduced under the heading of “personal budgets” already in the Netherlands²⁵ and under evaluation for potential implementation in Germany.²⁶ In Poland and Slovenia a “cash care envelope” is paid to the elderly if the community can not provide required services.²⁷

This system has favoured the transition of certain informal carers to formal service providers. The carer receives an allowance (pension credits in certain cases) which represents a kind of remuneration for caring.

At the same time long-term care policies moved from institutional care to home care. This policy becomes especially important in countries where institutional care had high levels before (notably Finland and Sweden).

Nowadays institutional care facilities are more diversified according to people’s needs and can be categorised as (1) the classical nursing home, orientated towards medical care aspects for care dependent elderly with a high level of care, (2) sheltered housing, where the elderly still live on their own but have specific common facilities and special low level services and (3) adapted housing meaning the structural alteration of a care-dependents person’s own home to suit their care needs (barrier free living). In addition tailor made intermediate services are mostly available such as day care and short term care facilities.

Not though that the deinstitutionalisation of dependent people without the necessary assistance to family carers may reduce labour participation of carers.

4.3 Substitutability or complementarity

Care may be provided by professionals or by informal sources. The informal sector includes mainly the family, relatives, friends and neighbours. A question concerns the frontier between help considered to be convenience assistance and help considered to be dependency care. The frequency and the time spent by the carer might be relevant criteria.

Another important aspect is that many persons may receive help from different sources. In fact, many persons cumulate informal help with formal home services. An important discussion concerns the substitutability or complementarity between formal and informal help. Analysis of different surveys provides mixed results. In certain cases formal and informal seem to be substitutes and in other cases they seem to be complementary.

In Sweden, family and public services are not total substitutes even in response to cutbacks²⁸. In the US, some evidence shows that an increase of formal help by 25% resulted in a decline by 3% only of informal care²⁹. Himes et al. (2001) find that formal care in Germany is more likely to be used by those in the poorest health, the single, or the childless. The presence of daughters increases both the use of family and formal care sources.

In any case, the lack of total substitution between formal and informal care implies that if we want to turn informal care into employment, we must keep in mind that a person receiving for example 38

²⁴ Daly and Lewis 2000 after Theobald 2005.

²⁵ Van Ewijk and Kelder 1999

²⁶ Arntz and Spermann 2003

²⁷ Mette 2005

²⁸ L. Johansson *et al.* (2003)

²⁹ Leontaridi, R., Bell, D. (2001).

hours per week of informal help will not “create” a full time caring job. In fact, the family will continue to provide part of the required help.

4.4 Intensity of care and labour issues

The number of hours spent caring has important impacts on labour participation. Also, the number of hours demanded by dependent elderly people is important for the quality of their life. Available econometric analysis suggests that the impact of informal care on the labour supply of men and women is similar and that a commitment of less than 10 hours has no significant statistical impact on labour supply. However, higher levels exert a negative impact on employment of carers compared to non-carers³⁰.

Econometric analysis of female respondents to the 1985 GHS found evidence of a threshold of 20 hours per week at which informal care-giving begins to have an adverse effect on women’s wage rates (Arkey et al. 2005). For women providing 20 or more caring hours per week, caring reduced the hourly wage rate by around ten per cent (Carmichael and Charles, 1998). Subsequent analysis of the 1990 GHS data on women aged 16 to 59, found that the effect of caring on the wage rate was smaller and less significant among those who were caring for less than ten hours per week (Carmichael and Charles, 2003a)

Difficulty in combining paid work and informal care seems to particularly affect those undertaking substantial hours of caring per week. Among people aged 16 to 74, only half of those providing between 20 and 49 hours per week were employed or self-employed in 2001; as were only three out of ten people providing 50 or more hours per week of care (H. Arksey et al. , 2005).

It is when caring is provided for around 20 hours a week or more that carers find it increasingly difficult to remain in paid employment (Princess Royal Trust for Carers 1995, Joshi 1995). Analysis of the 1995 GHS data suggests that, among working age carers of older people providing care for 20 hours a week or more, less than half (44 per cent) were in paid employment³¹.

In the UK, caring is most compatible with paid work when caring is not particularly intense (Phillips *et al* 2002, Mooney *et al* 2002). Caring can reduce levels of participation through lower hours of work, movement from full-time to part-time work or withdrawal from the labour market altogether. Withdrawal from the labour market may take the form of early retirement, to which care responsibilities may contribute³².

Penrod et al. (1995) find that primary care-providers who are not active on the labour force provide more hours of care per week than those who are employed³³.

Econometric analysis by Madden and Walker (1999) found that, after controlling for different factors, caring had a significant negative effect on women’s hours of work, but not on men’s. This may be because it is mainly people working part-time (rather than full-time) that reduce their hours of work (Henz, 2004) and relatively few men work part-time. At any rate, it seems that part-time jobs may be more flexible (Henz, 2004) in the sense that it may be easier to negotiate reduced hours of work when a job is part-time rather than full-time (H. Arksey *et al.*, 2005).

Of those doing caring work for less than 13 hours a week, only 16% of women are employed part-time but the rate doubles for those caring 13 hours or more³⁴.

³⁰ F. Carmichael and S. Charles (2003).

³¹ Linda Pickard (2004)

³² Linda Pickard (2004)

³³ Penrod *et al.* (1995)

³⁴ Holzman Jenkins (1998)

Edwards and Burkitt (2001) argued that “Flexible and part-time ways of working are only possible if you earn a big enough salary, or are supported by a partner with a higher salary”. Women living with better paid men are more likely to be carers than those living with less well paid men.

4.5 The impact of informal caring on employment

Both men and women are less likely to be in paid work than otherwise similar non-carers and when they are in paid work they earn significantly less given their human capital. For female carers, the employment rate declines as hours of caring increase. Concerning the decline of earnings, this decline is sharper for male carers (F. Carmichael and S. Charles, 2003).

Available data (e.g. ECHP) indicate a negative impact of care on the employment of carers. This effect seems to be stronger among men compared to women. Part-time is more important and more socially accepted for women. Women might combine caring and part-time work easier. This might help explain part of the difference. Different studies have also found that working aged female informal carers were earning less per hour than would have been expected given their human capital³⁵.

T. Viitanen³⁶ estimates the impact of informal caring on women’s labour force participation using the ECHP data for 13 countries. The impact of care seems to be influenced by the age of the respondent, with older women being more likely to care for an elderly person. The analysis of different sub-groups indicates that the impact is largest for middle aged women and also for single women in several EU countries. Middle-aged women in many of the countries in the sample are constrained in their labour force participation owing to informal elderly care: 45-49 year old women in Germany exhibit significant negative effects and a 10% level of significance in Austria, France, Greece and Portugal. The incidence of caring increases dramatically from age 40 onwards reaching a peak in the mid-50s. Although this analysis does not constitute a proper test of causality, it is noteworthy to point out that that from mid-40s onwards labour force participation also decreases considerably, which could indicate causality. Single women are constrained in labour force participation due to elderly care responsibilities in Germany, Greece, Italy and the Netherlands.

L. Crespo³⁷ estimates the causal effect of providing "intensive" informal care to elderly parents on labour market participation decisions for European women who are themselves approaching retirement. She uses the Survey of Health, Ageing and Retirement in Europe (SHARE) and finds that two groups of European countries strongly differ in terms of informal caregiving intensity within the immediate family and the use of formal care: the northern countries (Sweden, Denmark and The Netherlands), and the southern countries (Spain, Italy and Greece). However, the results show that for both the estimated effect of providing "intensive" informal care to elderly parents on the probability of labour participation is negative and large for both groups of countries i.e. caring for a dependent lead to retirement or a movement out of the labour market altogether. Furthermore, a substantially stronger effect is found when the "intensive" caregiving variable is treated as endogenous in the labour participation equation. This shows that the potential opportunity costs in terms of (reduced) employment associated with the provision of informal care by women are seriously underestimated under the exogeneity assumption of the caregiving regressor.

For women, working part-time while providing informal care increases their chances of being in work after caregiving ends relative to those not working; working fulltime increases them even more. Heavily involved carers are significantly less likely to be in paid work when caregiving ends. As the duration of caregiving increases, there is a significant reduction in the likelihood of being in paid work compared with non-carers³⁸.

³⁵ F. Carmichael and S. Charles (2003).

³⁶ Tarja K. Viitanen (2005)

³⁷ Laura Crespo (2007)

³⁸ Linda Pickard (2004)

Caring can have negative effects on employment in other ways. Trying to combine caring and working can have adverse effects on carers themselves, notably on their health which in turn affects work productivity and decreases expectations.

4.6 Care decisions and endogeneity

It is important to note a critic based on a possible self-selection effect. The degree of need of care and labour market participation of the carer seem to be related. The more intensive is the need for care the lesser the participation. This can be the result of two different kinds of selection processes: a) carers with heavy caring duties leave the job and therefore more of them are not employed. B) Employed persons can not take up the responsibility to care for a more severely disabled elderly mother or father with DALY or steady need of help. To conclude, the labour force participation of carers in working age is not substantially influenced by their caring role³⁹.

The relatively high incidence of part-time working among women can be both a cause and effect of providing care⁴⁰. Unemployed and part-time workers may assume the role of carer more easily inside a family. On the other hand, an informal carer has to combine work and care giving. Consequently, he might be pushed into part-time jobs.

An important critic has to be noted. Part-time work is not necessarily enabling the combination of care and work. Care of older people can not be handled as flexible as the care of older children. Older people are highly fixated on the carer and can not be easily taken along to run errands etc. Main obstacle in some countries is the lack of facilities for respite care or similar services (Cornelißen 2005).

It is undisputed that care and work are not easily reconciled. However, it is not clear whether people not employed were unemployed before they took up their care obligations or whether this unemployment even positively influenced their decision to care.

In Germany the majority of non-working carers was not in work before taking on care obligations. Of those who were employed before 27% gave up their work completely, 24% reduced working hours and 49% did not cut down their working hours at all. The decision to give up work completely was made mainly by married women. Women were not likely to exit the labour market when they were already working for a long time of their life and working fulltime. High job orientation and higher income seem to positively influence the decision to stay on the labour market and take up care at the same time (Cornelißen 2005).

Axel Heitmüller (2004) shows in an analysis of the British Household Panel Study for 2002 that endogeneity is likely to vary with the degree of freedom in the care decision and also that endogeneity mainly occurs in extra-residential and not in co-residential care. This means that the causality of leaving the labour market due to care obligations is not as straight forward as it seems. Measures to improve the simultaneity could also be special job training programmes for carers if their care decision was taken because of unemployability (Heitmüller 2004).

4.7 Time impact

The time dimension is an important aspect. It might imply difficulty to re-enter the labour market, lower social rights notably pension rights, less well paid jobs (taking into account hours worked), and jobs offering less prospects for promotion (Holzman Jenkins 1998).

³⁹ Ursula Dallinger (2002).

⁴⁰ Hilary Arksey, Peter Kemp, Caroline Glendinning, Inna Kotchetkova and Rosemary Tozer (2005), Carers' aspirations and decisions around work and retirement, Department for Work and Pensions, Research Report No 290, Corporate Document Services.

A number of studies have shown that caring has a negative effect on carers' earnings (Parker and Lawton 1994, Evandrou 1995). The lower earnings of carers were partly the result of lower hours of work, but the effect was compounded by lower than average hourly pay rates (Evandrou 1995). There are a number of possible explanations for the lower rates of pay of carers, including poor time-keeping and absenteeism, loss of seniority because of past breaks in employment, loss of promotion opportunities and the limited opportunities for earning high pay while working part-time (Joshi 1995). Part-time work in itself carries a penalty in respect to hourly wage rates (Joshi 1995)⁴¹.

Similarly, Heitmueller and Inglis (2004) found that being a carer was associated with lower hourly wages when other factors were controlled for. They also looked longitudinally at the wage differential between carers and non-carers between 1991 and 2002. They found that the overall gap was 11 per cent in 2002. For men in particular, much of the differential in earnings between carers and non-carers cannot be explained by differences in their characteristics.

The financial legacy of caring may also include an adverse effect on pensions. We may distinguish a 'wage penalty' as well as a 'pension penalty' to caring, especially for women. The evidence suggests that the effects of caring can last into retirement⁴². Carers accumulate fewer years of contributions than their counterparts who continued working. This can be reduced if credits are given to carers. Mooney *et al.*, (2002) note that, having an insufficient pension entitlement was an incentive for female carers aged over 50 to stay on in work.

4.8 Conclusions

The review of the literature yields a certain number of interesting conclusions:

- Policies to deinstitutionalise care dependent people may act as a barrier for labour participation if this policy is not accompanied with the relevant supporting services.
- Developing social services in order to meet the needs of care dependent people living in the community may increase free time for carers and thus labour participation.
- The number of hours spent caring has important impacts on labour participation and wage. Difficulty in combining paid work and informal care seems to particularly affect those undertaking substantial hours of caring per week.
- After controlling for different factors, caring has a significant negative effect on hours of work.
- Flexible and part-time ways of working are only possible if the carer earns a big enough salary, or is supported by a partner with a higher salary.
- Self selection: Persons out of the labour force may assume care tasks compared to employed persons inside the family. This means that the labour force participation of carers might be little influenced by their caring role.
- The time dimension is an important aspect. For women, working part-time while providing informal care increases their chances of being in work after care giving ends relative to those not working;
- Heavily involved carers are significantly less likely to be in paid work when care giving ends.

⁴¹ Review by Linda Pickard (2004)

⁴² (Evandrou and Falkingham 1993, Hancock & Jarvis 1994, Evandrou 1995, Joshi 1995, Evandrou and Glaser 2003)

- Caring might imply difficulty to re-enter the labour market, lower social rights notably pension rights, less well paid jobs and jobs offering less prospects for promotion.
- A number of studies have shown that caring has a negative effect on carers' earnings. Much of the differential in earnings between carers and non-carers cannot be explained by differences in their characteristics.
- The financial legacy of caring may also include an adverse effect on pensions. Carers accumulate fewer years of contributions than their counterparts who continued working. This can be reduced if credits are given to carers.

I.b. Participation and its impact on health

I.b.1. Work and health

1.1 Introduction

This chapter will review different factors affecting health. It will also discuss a certain number of methodological issues.

It will analyse personal factors such as age and education, institutional factors, working conditions and work-retirement trajectories.

It will focus on acquired longstanding health problems and disability and will exclude congenital health problems and disabilities.

Before examining the relationship between the reported prevalence of longstanding health problems and disability and a range of other factors, there is a need to clarify what is really measured by the self-reported longstanding health problems.

These measures are subjective and consequently might not be comparable across countries in the sense that people in some countries might be more prone to report that they have a longstanding health problems and disability. Different thresholds might be used by individuals or categories of individuals. Certain persons might have higher thresholds reflecting higher norms. If differences in reporting styles are taken into account, cross-country variations in general health are reduced but not eliminated⁴³.

Despite these remarks, self assessed health has been shown to be a powerful predictor of subsequent mortality (see e.g., Idler and Kasl (1995), Idler and Benyamini (1997)) and its predictive power does not appear to vary across socioeconomic groups (see e.g., Burström and Fredlund (2001)). Categorical measures of self assessed health have been shown to be good predictors of subsequent use of medical care (see e.g., van Doorslaer et al. (2000), van Doorslaer, Koolman and Jones (2004)).

Socioeconomic inequalities in self assessed health have been a focus of research (see e.g., van Doorslaer et al. (1997), van Doorslaer and Koolman (2004), van Ourti (2003)) and have been shown to predict inequalities in mortality (see e.g., van Doorslaer and Gerdtham (2003)).

1.2 Socio-economic factors affecting health

1.2.1 The justification bias

Even if we assume that the heterogeneity (subjectivity) issue is absent, self-assessed longstanding health problems and disability might be biased by what is called the justification bias.

For some categories, there is a social and economic incentive to misreport. Due to social pressures unemployed or inactive people might be pushed to misreport the extent of longstanding health problems and disability in order to justify their condition. This is the ‘justification bias’: longstanding health problems and disability become a justification for choosing non-employment. Conversely, there

⁴³ Hendrik Jürges (2006)

may also be an incentive to underestimate longstanding health problems and disability status on the grounds of stigmatisation.⁴⁴ From this point of view less visible impairments might be underestimated.

The review of the literature by M. Jones (2005), finds that the empirical evidence on the bias associated with self reported longstanding health problems and disability is mixed.

The bias towards over-reporting longstanding health problems and disability has to be treated with caution. In fact employed people report lower chronic illness and disability prevalence compared to unemployed or inactive but this comparison is irrelevant. There is a selection bias. People with chronic illness or disability have a higher probability to enter inactivity.

Certain researchers⁴⁵ consider that using 'Employment' as an explanatory variable reduces the endogeneity bias. In fact, employment may have a direct impact on disability through work effort (negative: stress, work hazards, etc ;), better income (positive); etc; the different channels work in different directions and consequently the bias might be less important.

Employment participation may affect longstanding health problems – activity limitations through the following channels⁴⁶ :

- the stress and physical demands of work may cause health problems and impairments; the coefficient is positive;
- Employment may affect disability through an income effect. Higher resources may help treat better chronic illness, etc. The coefficient is negative.
- Justification hypothesis: a person who is unemployed and feels a shame is pushed to claim disability in order to give a socially acceptable reason for non employment. The coefficient is negative if holding a job is 1 and no job equal 0;

1.2.2 Personal characteristics

Age and gender are often used to explain the prevalence of chronic illness and disability. One could expect that the prevalence increases with age, but the impact of gender is uncertain. Genetic characteristics have also been proposed as explanatory variables.

The marital status has also been used by several researchers. Lillard and Panis (1996)⁴⁷ argue that marriage has two different effects on health: protective and selective. 1) The protective effect means that married people are healthier because they receive family care. 2) In contrast, the selective effect has two opposite components. First, because of the protective effect, people with lower health status will put more effort in seeking marriage (selective effect is negative because marriage is associated with lower health status). Second, it is easier for healthy people to get married because they may be more attractive in the marriage market (positive selective effect).

Origin and colour has also been advanced. Origin might reflect different lifestyles, but this variable is also correlated with income and occupations.

1.2.3 Education

Education might affect the probability of a chronic illness and disability through different channels. The education is correlated with qualifications and thus might reflect the impact of working conditions. A high educational level might imply better working conditions and thus a lower risk. Education is also related to the level of income. A higher income might imply a higher capacity to

⁴⁴ Bound (1989)

⁴⁵ Baldwin or Haveman

⁴⁶ Baldwin, Marjorie, and William G. Johnson (1994)

⁴⁷ L.A. Lillard, and C.W.A. Panis. (2002)

treat health or proceed to health investments. Finally, education might reflect lifestyles. A higher education might mean a better knowledge of risk factors and hence a healthier life, which in turn decreases the probability of chronic illness and impairments.

It is difficult to estimate the impact of each factor as these variables are correlated.

The Dutch Ministry of Health, Welfare and Sport notes that men with primary education live five years shorter than men with higher vocational or university education. For women, this difference is two-and-a-half years. It concludes that socio-economic health differences have apparently not diminished during the last ten years and that there are major differences in lifestyles among various population groups. It notes that poor health, illness and premature death are more prevalent in some population groups than in others. Particularly people with limited education and low incomes are less healthy, including many immigrants. Similar results have been found in Belgium. The level of education has a strong positive impact on life expectancy and on life expectancy without disability.

Table I.2: Life expectancy at 65 and 80 years old in Belgium (in 1997)

	Life expectancy				Life expectancy without disability			
	Males		Females		Males		Females	
	65	80	65	80	65	80	65	80
Level of education								
Primary	14,4	6,3	19,0	8,4	6,3	0,8	6,6	1,0
Higher level - long duration	17,0	7,7	21,2	9,5	8,1	1,8	18,4	9,4

Source: Bossuyt N., Van Oyen H. (2002)

Silventoinen *et al.* (2005) studied a sample of 864 men and 1045 women aged 45-64 without history of coronary heart disease (CHD). The metabolic syndrome was less prevalent in subjects with university education compared with basic level education. Adjusting for health behavioural factors had only a slight effect on the educational gradient. An educational gradient in CHD incidence was clear, and adjustment for the metabolic syndrome attenuated this gradient only slightly. In conclusion, educational differences in the metabolic syndrome and CHD incidence were clear in this Finnish sample.

C.J.M. Schrijvers *et al.* (1999) examined how much of the association of education with mortality was explained by health-related behaviours versus wealth factors. They used the Longitudinal Study on Socio-economic Differences in the Netherlands covering a sample of people aged 15-74 years old. The behavioural factors included alcohol, smoking, BMI and physical activity. The wealth factor included financial problems, employment status, and a proxy for income. Using regressions to control for the different factors, they estimated that over 50% of the education-mortality association was explained in total by wealth factors. This suggests that improving the material situation of people might substantially reduce educational differences in mortality, both directly and through behavioural factors.

In the previous discussion, we have treated education as an exogenous factor affecting the prevalence of disability. Critics advance that education is an endogenous variable meaning that chronic illness and disability may affect the educational level. A review of the literature by W. Groot and H. Maasen⁴⁸ concludes that “the effect of education on health represents a genuine causal effect, that the reverse effect running from health to education is relatively small (at least for adults), and that there are common factors – most notably time preferences – that affect both investments in health and education”.

In addition, education (the positive effect of schooling) seems to have an active protective effect through benefits from knowledge accumulation on health information and services (E. Cambois,

⁴⁸ Wim Groot and Henriëtte Maassen van den Brink

2004). The progressive improvement of educational level ought to improve health in the whole population.

The correlation between income and education is well established. However, the impact of the educational level is difficult to identify, as it is difficult to separate it from income effects and working conditions. In fact, a low education might mean previous unskilled jobs with low salaries and bad working conditions. Some researchers have argued that the educational level is a factor by itself affecting health. In fact, low education is often associated with risky lifestyles.

The relative inequality indicates that less educated persons (i.e. a hypothetical man at the bottom of the educational hierarchy) have a higher mortality than the most educated people (at the top of the hierarchy). This applies to elderly people too. However, this inequality is lower compared to younger groups. The evolution through time indicates that, in most cases, the relative inequality has increased indicating a relative deterioration for low educated groups.

Several studies have found that mortality and morbidity differences by educational level have increased or remain unchanged⁴⁹, during the last years (e.g. Finland and Netherlands).

1.2.4 Income and Employment

Several authors⁵⁰ argue that income and wealth affects the probability to report a longstanding health problems and disability. In fact, higher income means higher living standards and higher health investments. Consequently, an increase of income decreases the probability to report a longstanding health problems and disability.

Furthermore, it is not the absolute situation of an individual which might affect, notably its mental (psychological) well-being but its relative position in the society. Low place in the social rank creates stress and possibly reveals bad lifestyles. Relative income becomes the determinant variable.

Income raises the fundamental question of whether income determines health and disability or the inverse. Even, if we eliminate measurement errors and justification bias, the endogeneity issue related to income remains. Whether we use income or wage the endogeneity problem remains. A chronic illness or activity limitation may reduce work opportunities or work productivity and thus reduce the earnings capacity of a person with a disability. Consequently, we have to take into account the interaction between longstanding health problems and income with the formulation of a system which allows income to affect longstanding health problems / activity limitations and longstanding health problems / activity limitations to affect income (e.g. through wage or employment)⁵¹.

1.2.5 Lifestyles

The debate on the causes of socioeconomic inequalities in health has enlarged the potential contributors to behavioural factors⁵². The behavioural explanation of socioeconomic inequalities in health focuses on lifestyles (smoking, dietary habits, physical activity, etc.).

⁴⁹ I.M.A. Joung *et al.* 2000.

⁵⁰ See a review in: 1) Income Inequality and Self-Rated Health Status: Evidence from the European Community Household Panel; Vincent Hildebrand and Philippe Van Kerm; May 2, 2006. 2) Health and wealth: empirical findings and political consequences; Andrew M. Jones, Eddy van Doorslaer, Teresa Bago d'Uva, Silvia Balia, Lynn Gambin, Cristina Hernández Quevedo, Xander Koolman and Nigel Rice; PREPARED FOR PERSPEKTIVEN DER WIRTSCHAFTSPOLITIK OCTOBER 2005

⁵¹ 1) The Interrelationship between Income, Health and Employment Status: K STRONKS, H VAN DE MHEEN, J VAN DEN BOS AND J P MACKENBACH; International Journal of Epidemiology Vol 26, No 3, 1997. 2) A. M. Jones *et al.* 2005.

⁵² Carola T M. Schrijvers, PhD, Karien Stronks, H. Dike van de Mheen, and Johan P Mackenbach.

Schrijvers *et al* (1999) note that, when we study the effect of behavioural and economic factors on health, it is important to consider the overlap between both types of factors. Part of the unhealthy behaviour in the lower socioeconomic groups is likely to be induced by adverse material conditions. For example, people might smoke to compensate for unfavourable living conditions such as a low income. The independent contribution of behavioural factors to the explanation of socioeconomic inequalities in health is therefore overestimated. They analyse longitudinal Dutch data and find that economic factors play an important role in explaining the relation between educational level and mortality. However, the results show that behavioural factors have an independent effect. Therefore, health promoting activities aimed at risk factors such as smoking and lack of physical activity might contribute to a reduction of mortality differences by educational level.

1.2.6 Institutional factors

Cultural factors are often advanced as factors explaining differences across countries or across regions inside a country. The effect of culture is sometimes associated with the way that longstanding health problems and activity limitations are represented in different countries as reflected in national definitions of the term, especially in legislation. ‘Social standards’, therefore, are thought to be mirrored in the way that longstanding health problems and activity limitations are legally defined in the country in question. In other words, countries with wide definitions in their social protection systems will tend to have high rates of people declaring longstanding health problems and activity limitations. A number of studies (e.g. Benitez-Silva *et al.*) have found that people are aware of the criteria used by social security systems and behave as if they were applying the same criteria when reporting their own condition in this regard.

Institutional factors which might affect reporting chronic illness and disability are minimum level of invalidity required for the grant of an invalidity benefit. Another factor is the replacement rate i.e. the ratio of invalidity benefits relative to the wage rate.

Finally, the national health policies are important determinants. The argument is that strong national health and prevention policies may reduce health and disability risks. Furthermore, such policies may ensure a better rehabilitation, following a health accident. Due to endogeneity bias (chronic sickness affects total expenditure on health) this indicator has been rarely used.

1.3 Working conditions and Health

1.3.1 Working conditions and life expectancy

Occupation plays an important role, separate from income, often associated with working conditions. Physical effort, psychological stress, accidents and toxic agents might have an important impact on health. During time they accumulate and their effects might appear after retirement age.

The cumulative effects might increase till retirement age, and one could expect a decrease after retirement but not a complete disappearance.

M. Beatson and M. Coleman estimate the economic cost of accidents at work and work-related ill health at between 1.4% (UK) and 8.3% (Sweden) of the GNP⁵³. According to the European Agency for Safety and Health at Work, the costs of work-related illness range from 2,6% to 3,8% of GNP.

⁵³ Bjurström LM. 1997
Beatson M, Coleman M.

E. Cambois et al. (2001) study the experiences of French adult men in three major occupational classes: managers, manual workers, and an intermediary occupational group. They use life table models and show that managers have longer life expectancy and longer disability-free life expectancy (DFLE) than manual workers. They argue that concurrent increase in life expectancy and DFLE during the period maintained the occupational disparities in health, although the years lived with disability declined for all groups, as for the entire French population⁵⁴. Also, a longitudinal study in France finds a differential for mortality risk.

Table I.3: Life expectancy at 60 years by occupational group in France (in 1991)

	Managers	Intermediary	Manual workers	Total male population
Life expectancy (in years)	21,1	20,4	18,0	19,2
DFLE (in years)	17,0	14,9	12,8	14,3

DFLE: Disability-free life expectancy

Source: E. Cambois *et al.* (2001).

In Italy, life expectancy at 60 is 3 years less for blue collar workers than for managers⁵⁵.

The author notes that over a period of 20 years the rates have only slightly changed. All manual workers (except foremen) have a standardized mortality rate higher than the average. Significant mortality differentials remain according to the level of education while controlling for occupational classes. Cambois finds that the improvement in the average level of education has been less for the unskilled workers than for the whole manual worker class and relative risks of mortality in the least skilled classes tend to increase.

The Finish data below indicate that not only occupational inequalities persist but also that life gains are higher for non-manual compared to manual workers. Furthermore, despite significant improvements in life expectancy, the differences between socio-economic groups are large both in mortality and in morbidity⁵⁶. The socio-economic differences in mortality have not decreased, but even increased in some respects during the last decades. The average life expectancy of a male upper-level white-collar worker of 35 is 5-6 years longer than that of a male blue-collar worker.

Table I.4: Life expectancy at 35 by occupational group in Finland

	Men		Women	
	Manual	Non-manual	Manual	Non-manual
1971-1975	33,53	36,58	41,79	43,35
1991-1995	37,30	41,68	44,80	46,99
	3,77	5,10	3,01	3,64

Source: P. Martikainen et Al. (2001)

Concerning the risk of developing diabetes, Connolly et al. (2000) find an association between socio-economic status and the prevalence of type-2 diabetes in individuals in their middle years of life. Diabetes is a serious and costly disease, which is becoming increasingly common in disadvantaged minorities. Diabetes related deaths are higher among blue collars (1.8 per 100.000) than among white collars (0.6 per 100.000).⁵⁷

The UK Department of Health notes that, in the early 1970s death rates among men of working age were almost twice as high for unskilled groups as they were for professional groups. By the early 1990s, death rates were almost three times higher among unskilled groups. Consequently, the government's aim is to reduce health inequalities by tackling the wider determinants of health inequalities, such as poverty, poor educational outcomes, poor housing, etc.

⁵⁴ Emmanuelle Cambois, Jean-Marie Robine and Mark D. Hayward (2001).

⁵⁵ Caselli, Graziella; Peracchi, Franco; Barbi, Elisabetta; Lipsi, Rosa M (2003)

⁵⁶ Lahelma E, Koskinen S (2002).

⁵⁷ Data refer to France: white collars refers to "cadres supérieurs, professions libérales", blue collars refer to "ouvriers, employés".

Kunst *et al.* (1998) provide an interesting estimation of mortality rates in different European countries. They use the mortality rate ratio comparing manual classes to non-manual classes for men aged 45-59. They find that the manual to non-manual mortality ratio is greater than 1 in all countries and there is little difference across countries (except in France). The mortality rate ratio varies between 1,33 and 1,44 (except France and Finland). Among males aged 60-64 years, most rates lie between 1,21 and 1,33.

Furthermore, inequalities increased in all countries between the 1970s and 1990s. T. Blakely argues⁵⁸ that any beneficial effect of egalitarian policies concerning health affects both high and low socio-economic groups evenly. Relative inequalities have increased more in Northern countries compared to Italy. However, data for Italy are partial.

Working conditions and notably work painfulness seem to be important determinants. A recent French study⁵⁹ finds that physical painfulness can be found in several jobs and in certain cases it has been diffused in a larger extent during the last years. They measure painfulness using different criteria like work effort, port de charges, to remain upright, work at high temperature, vibrations, etc. There is a significant accumulation of different painfulness factors among manual workers. About 10% of all categories report 3 or more painfulness factors but among manual workers this rate is 80%. There is also an increase of working time constraints.

Loprest *et al.*⁶⁰ find that in the US, men and women have different rates of longstanding health problems and disability, and that both men and women working in occupations with greater physical requirements exhibit higher rates of longstanding health problems and disability than other workers.

1.3.2 Occupational and sector specific effects

Not all occupations or sectors present the same risks in terms of working conditions, occupational accidents and health hazards. Consequently, it is important to take into account the working history of the individual in order to control for these specific factors. The main problem here is the correlation between education and occupation.

Education might play an independent impact on health and on mortality from occupational factors. Smith *et al.* (1998) argues that occupation and education refer to different periods of life and reflect specific life situations which explain the outcome of different diseases. Criteria such as education are related to childhood deprivation and the related health problems, while others tend to refer to adulthood and related working conditions, life conditions and lifestyles (Smith *et al.* 1998⁶¹, Shrijvers *et al.* 1999⁶²). These studies stress the independent detrimental impact on health of hard physical and mental work conditions, often associated to unskilled and manual occupations.

1.3.3 Job satisfaction, health and retirement

Job satisfaction seems to exert a strong impact on retirement decisions. B. Rapport (2006-1) presents the results of a survey of persons aged 54-59. He finds that persons in bad health, those who have done a dangerous job and those not satisfied with their job express the desire to retire early. Generally, the interviewees consider that the age of about 59 is the ideal age for retirement but due to constraints they envisage to retire at about 60 years. Women envisage retiring later. This is probably due to the fact

⁵⁸ Tony Blakely (2001).

⁵⁹ PENIBILITE ET RETRAITE : Rapport remis au Conseil d'orientation des retraites ; Yves STRUILLLOU Avril 2003

⁶⁰ Loprest, Pamela, Kalman Rupp, and Steven H. Sandell (1995)

⁶¹ Davey Smith *et al.* (1998)

⁶² Shrijvers, C.T *et al.* (1999).

that women have shorter insurance careers and need more years to build up pension rights. Also people satisfied with their work, with higher education, more qualified or living alone envisage retiring latter.

B. Rapport (2006-2) finds that a high job satisfaction may postpone retirement age without financial compensation. Also, a good health decreases the probability to retire early. Generally, higher socio-economic categories are more inclined to postpone their retirement age following a financial incentive. These are also the categories with the highest life expectancy.

Job satisfaction and working conditions are closely related. Both play an important role in health status and retirement decisions. A recent study of the Finnish Centre for Pensions (2004) finds that a long work history and mental strain caused by the work are the most common reasons for plans to retire early (etk.fi). The most important individual reason for early retirement is a long work history. The second-most common reason to retire early is the mental strain of the work. Of those who intended to retire before the age of 63 years 66% said that this had a large impact on their intention to retire. The study also finds that a higher pension is not very attractive if the work is found to cause mental strain or if the experiences of fatigue are dominating. Persons who find that they are in good health are on average more interested in continuing to work. Also highly-educated persons are interested in continuing to work, as are those whose spouse is still working.

Blanchet and Debrand (2007) use the first wave of SHARE to analyze the impact of health and satisfaction at work on preferences concerning age at retirement in 10 European countries. Preferences concerning age at retirement are measured by the rate of people wishing to retire as soon as possible. Job satisfaction and health are the most important factors influencing the wish to retire as soon as possible.

Given the constraints of bad work conditions and low health, the question is how workers adjust to this situation.

Ohashi (2004) studies older workers who are in their sixties and in the process of retiring from the labour market. He finds that as their physical strength, memory and work incentives decline with ages, older workers would adjust their way of working such as hours of work and work circumstances even if it is accompanied by a decrease in wages. He finds that as workers aged, they come to put more priority on hours of work, work circumstances, the human relation in the workshop and the contents of a job rather than on wages, as far as their economic constraint allows.

An interesting survey by MetLife Foundation of persons aged 50 to 70 in the USA reports that about 40% say that they plan to work part-time in retirement and only a small share expect to work part-time mainly for the income. However, a majority of those planning to work in retirement (53%) say that poor or declining health would be a major reason that they would not be able to act on their plans. Flexibility of work is also an important factor.

Finally, the European Community Household Panel (ECHP) reported a high number of people declaring a low job satisfaction in the Mediterranean countries. Indeed, in general, the Mediterranean countries are characterised by a low score both for the overall measure and for the different dimensions. Denmark and Austria range at the top. Similarly, SHARE presents a north-south dichotomy. Mediterranean countries report a low job satisfaction and a high percent of people wishing to retire as soon as possible.

The question is whether this is due to subjective reference levels specific for each country (cultural bias – i.e. people from different countries use a different satisfaction scale), or to socio-economic factors affecting job satisfaction (education, health, etc.). Nicoletti (2006) studied job satisfaction differences across countries. In order to account for the potential cultural bias, he rescales the measure of general job satisfaction. He defines different dummy variables to identify people with low levels of job satisfaction (e.g. a dummy variable taking value one for people whose level of job satisfaction is

bellow their national tenth percentile). He explains why people are dissatisfied using a fixed-effects logit model. He finds that satisfaction levels differ substantially across countries but this is at least in part due to a cultural bias in answering to satisfaction questions. Rescaling the job dissatisfaction dummies or, even better, rescaling the satisfaction measures with different job facets helps in reducing the difference in coefficient across countries (but does not eliminate differences).

A review of the literature including studies by psychologists and economist (A. C. D'Addio (2003) et al., L. Davoine (2006) and E. Johansson (2004)) indicate that generally:

- Wages have a positive effect on job satisfaction. A number of studies suggest that it is not absolute, but rather relative wages which count.
- Age has an U-shaped impact with a minimum at about 30 to 40. This might result from the fact that young workers could over-estimate their future earnings and have generally high expectations.
- being manager/supervisor increases job satisfaction
- Being male reduces job satisfaction in comparison to women ('gender paradox'). Certain argue that women generally expect less from their job and consequently feel more satisfied than men. One explanation might be that women have lower expectations due to perceived discrimination and have adapted their expectations accordingly.

Company policies may exert an important impact on job satisfaction and explain part of the differences across countries. Denmark has generally a high level of job satisfaction. It is important to note that more than 50% of the firms employing older workers have a senior policy. The offerings may consist of reduction of requirements to the worker (shorter working hours or less demanding tasks) or increasing the worker's resources (vocational training) (Simonsen, 2006)

1.3.4 Overtime work and health

There exist a number of studies indicating the negative effect of overtime work and work hardship on health and mortality. Some of those studies also show that because of their effect on health, both overtime work and work hardship lead to early retirement through disability insurance or other ways of exiting the labour force before the statutory age of retirement.

Two related questions are in order. First, are those work conditions mandatory or not? Second, if they are not mandatory, why do workers accept them? On the first question, one might distinguish three cases: (i) some firms impose overtime work as a way to keep production proceeding smoothly in a world of variable demand; (ii) is some other cases, unions and management agree on some package including overtime work; (iii) finally, there are situations where individuals choose freely to work overtime; this might include moonlighting.

The second question is why unions and workers agree on long work hours knowing their detrimental effect of health? Ignorance can be an explanation and myopia can be another explanation. Recent works in behavioural economics have underlined the capacity of individuals to act short-sightedly.

Overtime work certainly helps to drive the growth in output. But even if there are obvious advantages for firms to use these extra-hours, overtime work has unhealthy social costs. And the social costs associated with overtime work are particularly worrisome when the long hours are involuntary. More hours spent at work mean less time with the family, less time for leisure, less time for housework and less time for sleep. These sacrifices can be translated into increased risk for accidents and injuries, greater chronic fatigue, stress, and related diseases. In deed, overtime work is a serious public concern particularly in the health care sector.

Several studies have associated overtime and extended work schedules with an increased risk of hypertension, cardiovascular disease, fatigue, stress, depression, musculoskeletal disorders, chronic

infections, diabetes, general health complaints, and all cause mortality⁶³. Overtime has also an impact on sleep and sleepiness (Dalgren 2006). Results show a negative impact of overtime work on sleep and greater problems with fatigue and sleepiness.

We can mention two studies in particular, one about mortality and the other about occupational injuries and illness. First, we have Nylen *et al.* (2007) who studied mortality among women and men in Sweden relative to overtime work. Their results for overtime work of more than 5 hours a week show an association with increased mortality among women. The outcome may be explained by the fact that women are responsible for most unpaid work at home, and if combined with more than full time work, the total workload may pass a threshold with adverse health effects. Men had a reduced mortality relative to moderate overtime work, 5 hours a week or less, which may reflect a devotion to work or a stimulating work environment entailing positive health effects. However, this could also be a reflection of a healthy worker selection.

The impact of overtime and long work hours on occupational injuries and illness has been studied for the US by Dembe *et al.* in 2005. They found that work schedules involving long hours or overtime substantially increase the risk for occupational injuries and illnesses. Working in jobs with overtime schedules was associated with a 61% higher injury hazard rate compared to jobs without overtime. The results of this study suggest that jobs with long working hours are not more risky merely because they are concentrated in inherently hazardous industries or occupations, or because of the demographic characteristics of employees working those schedules. Their findings are consistent with the hypothesis that long working hours indirectly generate workplace accidents through a causal process, for instance, by inducing fatigue or stress in affected workers. The risk of injury was found to increase with the increasing length of the work schedule, even after controlling for the entire amount of working time spent “at risk” for injury.

Knowing the impact of overtime on health, the link between overtime and retirement is then obvious. With increased age, muscle force decreases, and more people are plagued with such health problems as cardiovascular disease. Reduced health may create a discrepancy between job requirements and working capabilities, which in turn may lead to early retirement, usually with a disability pension. We expect that this situation is most likely to occur in situations in which work entails mental stress, hard physical tasks and overtime. Some retirement models include working conditions as explanatory variables. Authors often consider autonomy, physical and mental strain, repetitive jobs and physical demand of jobs, but the number of hours worked and the prevalence of overtime work it is not often taken into account. Quinn (1978) found evidence that retirement probabilities are lower in tight labour markets and higher from jobs with undesirable characteristics. The latter is especially true for men in poor health. Blekesaune *et al.* (2005) for Norway also investigate the impact of working condition on individual retirement. Their findings indicate that disability retirement is related to physical job strains. Among men, both pathways of early retirement are related to low autonomy in job tasks. Furthermore, psychological job stress may reduce nondisability retirement.

Furthermore, there is evidence that, despite the short term benefits that make overtime attractive to employers, it may in the longer term create offsetting harm to organisation by decreasing quality, increasing mistakes, and reducing productivity.

The review of the literature has shown the negative effect of overtime work and work hardship on health and mortality. Some of those studies also show that because of their effect on health, both overtime work and work hardship lead to early retirement through disability insurance or other ways of exiting the labour force before the statutory age of retirement.

It seems quite established that overtime work and more generally hard working conditions have a negative effect on workers' health and eventually lead to early retirement through disability or other schemes and to premature mortality. This reality should induce governments to further regulate

⁶³ Fifty-two studies listed in a report by Caruso *et al.* in 2004.

overtime work and improve working conditions. Appropriate policy will naturally depends on circumstances. Overtime can be imposed by employers and defended in the name of competitiveness. In that case, there are reasons for regulation. It can arise from the workers themselves out of a mixture of ignorance and myopia. We then have a case where the government ought to adopt a paternalistic attitude and violate individuals' preferences in the name of their own good. Regulation and taxation can be the answer. When overtime occurs through moonlighting or any form of informal work, public action is naturally more difficult. The best tool in that case is information: to better explain the eventual consequences of overtime on individuals' welfare.

1.3.5 Extended and unusual working hours⁶⁴

Drawing on answers from managers who participated in the Establishment Survey on Working Time (ESWT survey), managers in non-standard hours establishments see themselves confronted at a higher than average level with absenteeism, motivation and staff turnover problems. Also, early retirement is a feature of many establishments operating at unusual and changing hours.

A. Kümmerling and S. Lehndorff show that establishments with unusual working hours in the 21 countries surveyed report problems with sickness and absenteeism more frequently than companies with no such working hours, or only a small incidence of unusual working hours.

Regular Saturday work is most prevalent in the UK, Cyprus, France and Ireland, whereas regular Sunday work is most common in the UK, Sweden, Finland and Latvia. Regular night work is strongest in the UK, the Czech Republic and Sweden, and regular work at changing hours is most prevalent in Finland, Sweden and Poland. Three southern European countries – Portugal, Spain and Greece – show particularly low shares of companies requiring their employees to work regularly at unusual hours.

According to manager assessment, the situation appears to be worse in establishments that have night work and changing working hours – for both incidences, data indicate that the likelihood of encountering difficulties with sickness and absenteeism is 1.6 times greater than in establishments that do not observe such hours. As for the incidence of weekend work, data show similar results for both the cases of Saturday and Sunday work. Here, the likelihood of sickness and absenteeism problems is still 1.3 times greater compared to establishments that do not require staff to work on the weekend.

Overtime work is much more widespread for men than for women. The average overtime hours is more important for men than for women.

We can also look at the impact of working long hours on some other indicators of working conditions, such as health and work-life balance.

Working very long hours may increase health and safety risks: those who work more than 48 hours a week are more likely to consider their health and safety at risk because of their work (twice as many as other workers), and that their job affects their health.

The greatest negative effect of long working hours is on work–life balance: three times as many workers working long hours compared to other workers feel that their working hours do not fit in with their social and family commitments.

Besides looking at long working hours in general, we can also look at the overtime work of older European workers (50-64years old). It's important to look precisely at this category of worker when you deal with retirement issue. We took the difference between the working time as scheduled in the working contract and the working time really done every week.

⁶⁴This section draws on a study by: Angelika Kümmerling and Steffen Lehndorff, 2007.

1.4 Retirement process and health

Several studies have established that unemployment affects adversely health. Mclean et al. (2005)⁶⁵ find that there is a strong association between unemployment and measures of psychological and psychiatric morbidity. Upon re-employment, there appears to be a reversal of these effects. While the direction of causality is difficult to determine, unemployment is considered to be a significant cause of psychological distress in itself.

A certain number of recent studies have investigated how the retirement process affects health after retirement. An important distinction lies on whether the person retires following a personal decision (voluntary retirement) or is the result of an external constraint (dismissal and forced retirement).

W. T. Gallo et al. (2006) investigated the association between involuntary job loss among workers nearing retirement and long-term changes in depressive symptoms in the US. They analysed longitudinal data from the Health and Retirement Survey. Their findings identify older workers with limited wealth as an important group for which the potential effect of involuntary job separation in the years preceding retirement is ongoing (enduring) adverse mental health. They found no effect of involuntary job loss for high net worth individuals at the later survey waves.

As noted in the chapter on “Health and labour market participation” persons with fewer assets are incited to retire latter. Furthermore, this group might include people with chronic illness. In these conditions, it appears that “forced” retirement might lead into poverty and thus create stress and aggravate health problems after retirement.

Another important source of stress might be care giving. M. S. Szinovacz, and A. Davey (2004) find that women retirees in the US who stopped employment and were either forced into retirement or perceived their retirement as too early reported significantly more depressive symptoms with increasing spouse activities of daily living (ADLs) limitations. There is no similar effect for men. In contrast, for working retirees who retired on time, depressive symptoms decrease with increasing spouse ADLs. The results suggest that both type of retirement transition and marital contexts such as spouse's disability influence postretirement well-being, and these effects differ by gender.

It is important to note the difference between men and women probably stemming from the fact that women are more often care providers than men. Also, it appears that the combination of caring and “forced” retirement aggravates health problems. Probably, a “forced” retirement might imply a lower income and decrease self-esteem. On the contrary, caring after normal retirement channels might be more in accord with social norms and distribution of roles inside the family.

The traditional distribution of roles seems to play an important role on mental health after retirement. M. E. Szinovacz and A. Davey (2004) find that recently retired men seem to be negatively affected by their spouses' continuous employment when compared with men whose wives were continuously not employed. In contrast, spouses' joint retirement has a beneficial influence on both recently retired and longer-retired men. However, for recently retired men, the positive effect of wives' retirement seems to be contingent on spouses' enjoyment of joint activities.

The transition from work to retirement seems to be affect health through different channels, notably financial considerations, expectations and social norms. H. van Solinge and K. Henkens (2005) examine the extent to which adjustment to retirement is influenced by psychological factors shaped by individual expectations and evaluations prior to retirement. They use panel data from older Dutch couples who experienced the transition into retirement of one of the partners. They use ordinary least squares and three-stage least squares regression models to explain adjustment to retirement by both partners. As previous studies they find that the context in which the transition is made as well as individual psychological factors are important determinants. A strong “quantitative” attachment to

⁶⁵ Mclean, C., Carmona, C., Francis, S., Wohlgemuth, C. and Mulvihill, C. (2005).

work (full-time jobs, long work histories), a lack of control over the transition, retirement anxiety (negative preretirement expectations), and low scores on self-efficacy are predictors of difficult adjustment. The extent to which partners influence each other in the process of adjusting to retirement appears to be limited.

Also, the meaning of marital conflict and marital solidarity are affected by the transition to retirement. A. Davey and M. E. Szinovacz (2004) use the US data of the National Survey of Families and Households. Results suggest that the structure of marital conflict is unaffected by husbands' and wives' transition to retirement, but that wives' continued employment may be associated with greater conflict longitudinally. They argue that husbands' and wives' constructs of marital solidarity differ from one another; they were unaffected by wives' retirement but converged with husbands' retirement.

Retirement planning is not necessarily a process with an endpoint of "full retirement." Some studies suggest that freely choosing to retire and satisfaction with the retirement experience are the factors that significantly influence the decision to remain retired. Respondents who return to work are more likely to be female, to have children, and to be financially supporting dependents. On average, those that rejoin the labor force are more likely to have had the initial decision to retire forced upon them and are significantly less satisfied with the retirement experience⁶⁶.

1.5 Conclusions and policy implications

Different researchers have stressed:

- Education and working conditions seem to exert a determinant role on health.
- The impact of education and income are difficult to separate.
- There is a gap in life expectancy between lower and higher level occupations. This differential in health and life expectancy seems to persist through time.
- People reach legal retirement age with a different life expectancy and consequently different attitudes concerning work and leisure. Activation policies concerning labour participation of older people and social participation of the elderly ought to take into account this life expectancy differential.
- Uniform policies risk reaching only educated people who had higher level occupations and benefit from a good health and higher life expectancy at retirement.
- High job satisfaction and good working conditions may postpone retirement age.
- The existence of flexible work time arrangements seems to play an important role. Part-time work appears to be an important factor.
- Involuntary retirement might create stress and aggravate existing health problems.
- A strong attachment to work (full-time jobs, long work histories) and a lack of control over the transition are predictors of difficult adjustment.
- Flexibility in retirement processes may improve health after retirement and reduce health costs.

⁶⁶ Karen Eilers Lahey, Doseong Kim, Melinda L. Newman (2006)

- Overtime work and more generally hard working conditions have a negative effect on workers' health. This reality should induce governments to further regulate overtime work and improve working conditions or favour agreements between social partners.

I.b.2. Active ageing and health

2.1 Introduction

Over the past 25 years, a great deal of evidence have been accumulated in neuropsychological studies indicating that advancing age is accompanied by systematic decline in performance on a wide variety of cognitive tasks. Among them, orientation, memory, verbal fluency or reasoning, all of them measured by the way of simple cognitive tests that are generally administrated to patients, but also nowadays in face to face surveys addressed to the general population.

However, although this cognitive decline with age has been defined, this process is not unavoidable. There exist many examples of elderly people who keep high cognitive functions, even at extreme age.

In the following, we will study first how activity at older age affects cognitive functioning.

Next, we will analyse how specific activities e.g. volunteering affect health. Life expectancy is steadily increasing. At the age 60-64 years females can still expect to live approximately 24 years and males 20 years more. Volunteering may be an important activity for the volunteer and the community.

Finally, we will discuss the role of social capital. Recent studies stress the positive impact of “social capital” on general well being and health of citizens. The concept of social capital shall be summarised and its potential positive impact discussed on the basis of the findings of contemporary studies.

2.2 Activity and cognitive functioning

2.2.1 Factors affecting cognitive capacity

Persons with high functional reserve may have increased capacity to keep learning and adapting despite age-related changes. This view has been developed in more functional terms by Stern (2002) and Scarmeas and Stern (2003) with the concept of “cognitive reserve”. For Scarmeas and Stern (2003), cognitive reserve related back to the fact that innate intelligence or aspects of life experience like educational or occupational attainments provide a reserve, in the form of a set of skills or repertoires that allows some people to prevent cognitive decline associated with normal aging or Alzheimer’s disease.

Recent researches tried to identify parameters contributing to the development of cognitive functions. Education is largely recognized as having an impact on cognitive functioning, and is thought to support the cognitive reserve capacity (e.g. Le Carret et al., 2003). Some studies confirming this idea have suggested that people with a high educational level have lower risk of developing dementia compared to people with a low educational level (Letenneur et al., 1999). But several studies have also suggested that differential susceptibility to age-related cognitive decline or to Alzheimer’s disease is related to variables, such as: occupation, professional or leisure activities, and life style (Fillit et al., 2002; Fratiglioni et al., 2004). All these findings on cognitive reserve may have important implications for the structure of retirement in old age. Keeping occupational activities as far as possible may contribute to maintain cognitive functioning in old age, preventing in this way, at least partially, some forms of dependency related with diminishing autonomy.

In SHARE, cognitive functioning was measured using short and simple tests of orientation, memory (learning and recall of a list of ten words), verbal fluency (a test of executive functioning) and numeracy (arithmetical calculations). Adam et al. (2007) decided to compute a global measure of cognitive functioning by focusing on two key cognitive domains: episodic memory (with the word list recall task) and executive functioning (with the semantic fluency task). It is widely recognized that episodic memory and executive functioning are two cognitive domains that are particularly sensitive to cognitive aging.

The memory task integrated in the survey was a test of verbal learning and recall, where the participants were required to learn a list of ten common words. The memory score was calculated by adding the number of words recalled at the immediate and delayed recall phases (score ranging from 0 to 20). Executive functioning was assessed using a fluency task, which is a test of how quickly participants can think of words from a particular category; in this case, they had to name as many different animals as possible in one minute. The global assessment score is computed by averaging the standardized memory and fluency scores. It is assumed to represent a more global and more sensitive assessment of cognitive functioning.

The SHARE data indicate that cognitive functions decline systematically with age, e. g. the memory test varies from 9.9 to 6.0 words in average from 50-54 to 80-84 years old categories, as well as it increases systematically with years of education.

Adam et al.(2007) using a frontier approach find that, all other things being unchanged, for an average individual aged 60 and having study 10 years, one year more of education “compensates” 4 years of cognitive ageing.

In a recent meta-analysis including studies conducted from 1966 through 2001, Colcombe and Kramer (2003) showed that, aggregating across studies, fitness training has a positive effect on the cognitive functions of older people, and thus on the development and maintenance of a cognitive reserve.

Finally, S. Adam et al. (2007) show that living alone have a negative impact on the preservation of cognitive reserve; a result that is consistent with studies showing that social isolation or social disengagement is a risk factor for cognitive impairment among elderly persons (Fratiglioni et al., 2004).

In a second step the SFA model used by Adam et al. (2001) show, for a 60-year-old individual, the positive impact on cognitive functioning of variables directly associated with the notion of activities. For instance, a 60-year-old individual is expected to delay his/her cognitive aging by 1.03 to 1.30 years (depending of the model) if she/he continues to work instead of retiring, all other things been equal, and 3.23 to 4.08 years if she/he performs at least one non-professional activity.

The analysis also shows that the impact of physical activities varies as a function of frequency of these activities. Thus, the estimated benefit in terms of years of cognitive aging for a 60-year-old individual changes: (1) from 2.61 to 3.30 years when physical activities are performed *more than once a week* instead of *never or rather never* ; and, even more strikingly, (2) from 3.46 to 4.41 years in the case of moderate physical activities. The involvements of the two other variables representing mobility limitations or single-person household indicate effects lesser than one year of cognitive performance cost.

Globally, these results confirm similar observations, such as Menec, 2003, that show in a six-year longitudinal study a relation between everyday activities and successful aging. Or as Schooler et al. (1999) who showed that the level of complexity of an occupation positively influences the level of intellectual functioning. The protective effect of professional activities on cognitive aging should be all the greater the more these activities tend to mobilize cognitive resources.

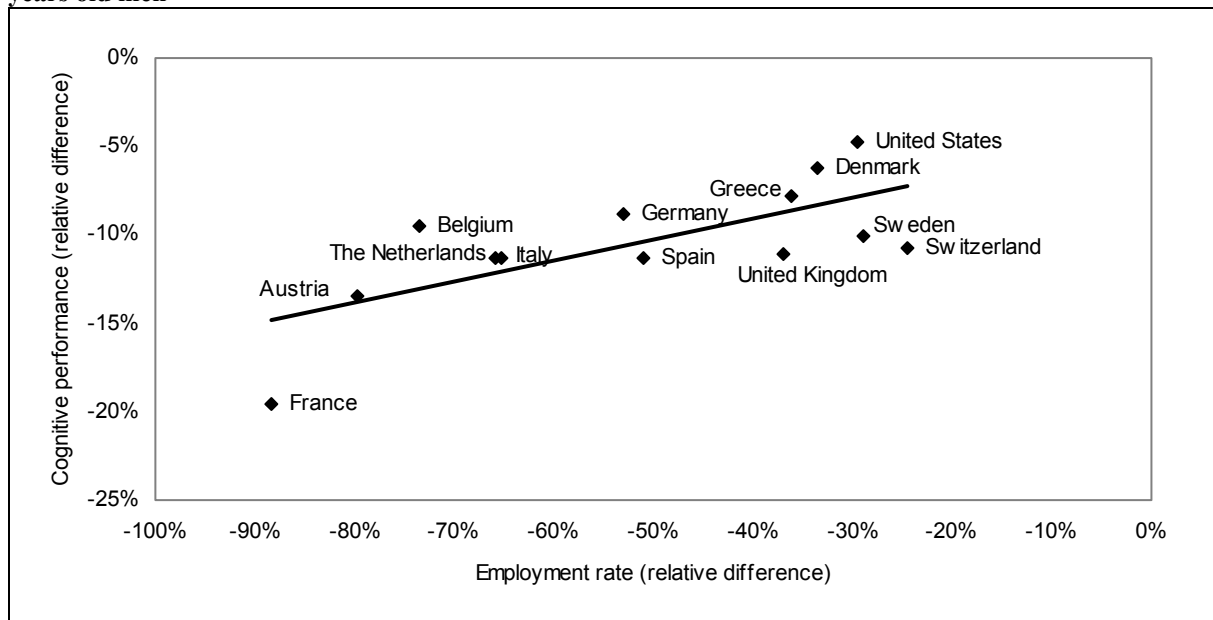
Moreover, the analyses show that these positive effects are slightly greater for non-professional activities compared to professional activities. So a 60-year-old individual who continues to work delays his/her cognitive aging by at least 1.03 years, while this individual delays cognitive aging by 3.23 years if he/she performs one non-professional activity. This superiority can be explained by the fact that non-professional occupational activities are mostly voluntary while professional activity are imposed for some people, and this constraint may generate depression and anxiety (factors that have negative effects on cognitive functioning). Some studies show that retirement can lead to a reduction in depressive symptomatology (e.g. Gallet al., 1997).

2.2.2 Activity and cognitive performance in Europe

The simultaneous interdisciplinary, international and longitudinal nature of the English Longitudinal Study on Ageing (ELSA) and the Survey on Health, Ageing and Retirement in Europe (SHARE), constitutes a living laboratory to identify the impact of institutions on labour force participation among the population aged 50 and more (Börsch-Supan et al., 2005).

Figure 1 illustrates what must be considered as a starting point in this research field. On the horizontal axis are reported the percentage points slowdown in employment rates when we compare the 50-54 to the 60-64 years old groups in HRS, ELSA and SHARE countries and, on the vertical axis, the slowdown in cognitive performances, a ten-words two-recall memory test, between the same age groups within the same countries. This figure highlights the potential unexpected consequences of early retirement programs on cognitive performances. Without anticipating the results of detailed statistical studies that would address, among others, the potential bidirectional causality between cognitive impairment and retirement, it appears that countries that performed better in terms of labour market participation among the elderly, also seem to have better prevented cognitive capacity decline and, as it is now well documented for the effect of educational skills, better prevented the early development of Alzheimer diseases.

Figure I.5: Employment rate and cognitive performance. Relative difference between 60-64 and 50-54 years old men



Source: Own calculations using ELSA, HRS and SHARE data

Globally, the results show a relation between everyday activities and successful aging, even if the data did not allow them to distinguish between cognitively stimulating (or non-stimulating) professional or occupational activities. However, in light of studies showing that the level of complexity of an occupation positively influences the level of intellectual functioning (e.g., Schooler et al., 1999, for professional activities; Hultsch et al., 1999, for social and new-information-processing activities), the protective effect of professional activities on cognitive aging should be all the greater the more these activities tend to mobilize cognitive resources.

Although these results clearly confirm the relationship between activity and cognitive functioning, the important and thorny problem of the “causal relation,” which is not always addressed in studies, remains to be considered. Indeed, the question is whether the decrease in cognitive functioning is the consequence of the reduction in activity or vice versa. As suggested by Schooler and Mulatu (2001), there is probably a reciprocal relation between cognitive functioning and cognitive stimulation.

Physical activity seems to be a strong predictor of successful ageing. In 2002, The World Health Organisation (WHO) reported that physical inactivity was estimated to cause 3-4% of the disease burden. Lack of physical activity, reduces notably the number of falls, reduces blood pressure and promotes mental health and social activity. WHO considers that, in order to benefit health, individuals should participate in at least 30 minutes of moderate intensity activity per five or more days a week but even intermittent daily activity of moderate intensity benefits health.

2.2.3 Overview by policy instrument

Preserving the cognitive capacity of elderly people is an essential component to ensuring they enjoy an independent and active life. Autonomy and competence in old age is essential and activation of cognitive functions is desirable. The combination of memory training and exercise seems to be a guarantee for healthy and satisfactory ageing and furthermore, assures sustainability.

Surveys show that dependency increases with age and participating in community and social life will constitute an important aspect of limitations faced by older people. The increase is expected to be more significant among the very old persons.

The literature about cognitive reserve (DIK, M. et al.) give us proofs of the efficiency of all kind of activity on the cognitive reserve preservation. Physical activity has shown to be inversely associated with cognitive decline in older people. Findings suggest a positive association between regular physical activity early in life and level of information processing speed at older age in men, not women. These findings suggest that early life physical activity may delay late-life cognitive deficits. This may supports prevention policy programs.

Physical inactivity increases with age and particularly among individuals aged over 65. Evidence support the need for older people to exercise, even when starting late in life. Public interventions to promote physical activity among older people have proven to be cost-effective in terms of additional years lived in good health.

Higher levels of cognitive activity and educational attainment are associated with higher level of cognition, reduced cognitive decline, and reduced risk of dementia in old age. Cognitive activity and education seems to bolster the brain's ability tolerate age-related neuropathology. Literature about cognitive reserve (Wilson R. et al.) found that retrospective estimates of level of cognitive activity across the life span were robustly related to late life cognitive activity. Thus cognitive activity in early life, along with early life socio-economic conditions appear to affect late life cognitive function in part by affecting cognitive lifestyle activities throughout adulthood and old age. Just like for physical activity, for education and intellectual activity is very important along the life/.To avoid early cognitive decline, prevention by childhood and adulthood education is the best solution according to the cognitive reserve literature.

In the coming decades, the WHO expects depression in industrialised countries to develop into a number one public illness. Because of the nature of the symptoms and the fact that many older people live alone, mental illness in older people could be largely under detected. Furthermore, mental health problems may be perceived by older people and their families, as well as by professionals, as an inevitable consequence of ageing, and not as a health problem, which requires action.

Older people represent a high-risk group and depression along with dementia is under diagnosed among them, since symptoms are often mistaken for the process of ageing. Mild cognitive impairment converts to dementia in laps of time of 3 to 4 years. Some of the predictors of these disorders are chronic illness, isolation and dependency. Preventive home visits offer the possibility to reach out to and to detect older people suffering from related psychological and mental disorders.

Studying and learning are regarded as an efficient measure in developing one's cognitive functioning.

WHO considers that active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance. The word “active” refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force.

2.3 Voluntary work and health

2.3.1 Characteristics of volunteer work and health

Most of the work done after the active working age could be characterized as benevolent or volunteer work. This work can roughly be divided into two types of work on the basis of the supplier or organizer of the work, and of the nature of the relationship between the worker and the supplier. In the first type, and what usually is understood as voluntary work, the organizer usually belongs to the so-called third sector (Jeremy Rifkin), which is also called a ‘civic society’, benevolent sector (UK), social economy (France), non-profit sector or non-governmental organizations. Ruohonen (2003) divides volunteering into four categories: a) philanthropy, b) peer support, c) participation, d) lobbying and influencing.

The size of the third sector or a civic society and the importance of voluntary work depend on how the welfare services are organized in the society. Particularly the role of the government (public sector) as an organizer and financier is decisive. Furthermore, the role of the households taking care of their members has an effect on the role and size of the voluntary work in that society.

Usually the distinction between caring and volunteering is that caring is confined to person-to-person emotional labour on behalf of family and friends, and volunteering is formalized and public (Wilson 2000), not including similar personal and emotional attachments to the helped. Correspondingly, taking care and nursing chronically seriously ill or handicapped spouses, parents or children can be a barrier to volunteering or even to accepting paid work.

Volunteering usually takes place in associations. But this is not necessarily so. On the other hand the activity of associations is not always about volunteering (Hilger 2006.)

In the following by volunteering we mean activity that is formal, given freely for others and is usually done unpaid. We first consider the effect of volunteering on wellbeing, health and longevity, mainly focusing on older persons.

Volunteering increases by education. Higher education increases awareness of problems, builds self-confidence, and also provides ways to find knowledge how to participate. Higher educated people are also more often asked to join to various organizations (Wilson 2000); 50% of people are willing to volunteer if only someone asked them (Graff 1991, Yeung 2002). Also other resources such as higher incomes and marriage increase volunteering (see Freeman 1999, Erlinghagen & Karsten 2005). However, time spent in volunteering is reversely related to incomes. In addition, religious or informal volunteering is not related to volunteering. (Wilson 2000.)

Volunteering is common in all countries and societies but it takes different forms in different times and cultures (Ruohonen 2003). It is likely that volunteer work would, in the same manner as paid work, be an important determinant of social identity that is one of the three basic factors of wellbeing (Allardt 1976).

In fact, there are studies suggesting the benevolent effect of voluntary work on health, wellbeing, vitality, self-esteem and longevity of those who volunteered (Graff 1991, Omoto 1993, van Willigen 2000, Thoits and Hewitt 2001, Musick and Wilson 2003, Li and Ferraro 2005). Particularly among older adults volunteer work has been found to decrease the risk of depression (Musick and Wilson 2003) and increase life satisfaction and perceived health (Van Willigen 2000, see Stevens-Roseman 2006).

A part of the association between volunteer work and health may be accounted for the better health of those who are volunteering: volunteers are found to have relatively good health; in average, they have better health than non-volunteers (Graff 1991, Freedman 1999, Thoits and Hewitt 2001, Stevens-Roseman 2006).

Why volunteer work would be healthy – what factors could account for the association between volunteering and good health? In the following we review some characteristics of volunteer work that may account for this association.

➤ *Self-identity*

Volunteer work might be important for self-identity (being) (Allardt 1976). It may give a structure for daily living and offer a chance for meaningful activities. Older volunteers as volunteers of all ages feel ‘needed and productive’ and may ‘meet one’s own expectations for later life’, which is an important characteristic to contribute to life satisfaction (Graff 1991, Stevens-Roseman 2006).

➤ *Sense of community*

According to this category, a person needs a sense of cohesion. In other words, the sense of belonging to a certain group or the community, being a part of the community and in the position where one can give something to other people or to the community (Graff 1991). In this regard, volunteer work may have a more important role for aged people who have left paid work and thus have fewer possibilities to belong to meaningful groups and feel sense of cohesion (see Warburton 2006). Volunteering may enhance or maintain community involvement and thus prevent loneliness and social insolation (Graff 1991, Warburton 2006). Among older adults (aged 65-74), being a formal volunteer moderated the negative effect of not being a partner, an employee or a parent on a person’s feeling of purpose (see Graff 1991, Greenfield and Marks 2004). According to Warburton (2006) volunteering provides an external ‘other-focus’; it provides a reason to be active and think beyond oneself.

➤ *Commitment – a key role*

For some people volunteering is a salient part of his or her identity; (s)he might change the actual volunteer work (s)he is involved in from time to time, but (s)he keeps on helping others in a way or other. For some volunteers volunteering might be a one-time performance while others take part every now and then (Musick and Wilson 2003). Warburton (2006) described how ‘...volunteering may provide a key role and a sense of purpose in life’. In accordance to this, if this role identity is lacking it is likely that voluntary work has no health effects.

➤ *Reciprocity*

Voluntary work often takes place in organized social settings that involve reciprocal social interactions between volunteers and the people they are trying to help, and, on the other hand, among the volunteers themselves (Musick and Manini 2003; Reynolds 2006). These interactions are usually positive and emotionally warm (Musick and Manini 2003). Thus voluntary work may enhance social capital of the community (Putnam 2000). An individual’s commitment to and interactions with his or her immediate surroundings, and society in general, affects health or disease defences and ‘general susceptibility’, which in turn affect morbidity and mortality risk through psychological processes (see Pensola 2003, Lundberg and Vågerö 1988:55, Syme and Berkman 1976). Social integration is supposed to affect health both directly and indirectly via social support (Hyypä and Mäki 2000).

➤ *Healthy volunteers*

A part of the association between volunteer work and health may be accounted for the better health of those who are volunteering: volunteers are found to have relatively good health; in average, they have better health than non-volunteers (Graff 1991, Freedman 1999, Thoits and Hewitt 2001, Stevens-Roseman 2006). On average, volunteering is more common among those who have at least fair health than among those whose health is deteriorated (see also Part III). There is evidence that functional health problems prevent people volunteering while depression may enhance subsequent volunteering; in this case formal voluntarism may work as a means of compensation (Li and Ferraro 2005, Warburton 2006). Volunteering can also work as a mobilizing or motivating force and as a part of rehabilitation during a recovery period after a trauma or illness (Graff 1991).

The relation between health and volunteering seems to be a two direction relation.

➤ *Active life styles*

One possibility for health-related effects could be through an active life style. The higher the active energy expenditure of older adults (aged 70 and over), the lower the risk of death (Manini 2006). Non-sitting volunteering is one type of activity. On the other hand, activity – that has effect on health – accumulates; satisfying volunteer work can be stimulating and provide energy for other types of activities (see Graff 1991). Indeed, volunteers of all ages have been found to have higher levels of formal and informal social interaction than non-volunteers (Musick and Wilson 2003).

Older people represent a huge potential for intergenerational voluntary work. The more this is utilised, the more evident it becomes that senior citizens are not merely passive contribution recipients, but themselves active contributors to society. This voluntary work is not only indispensable for the community, but it also offers older people who have retired the opportunity to find meaning and fulfilment in their lives, thus fulfilling the intention of active ageing. (Center for Population 2006.).

2.3.2 Prerequisites for health effects

In order to bring beneficial effect on health, volunteer work should have the following characteristics:

➤ *Face-to-face work*

There is evidence showing that face-to-face volunteer work has a greater effect on quality of life of the older volunteer workers than indirect approaches (Graff 1991, Healthy aging 2006).

➤ *Voluntary*

If a voluntary work is not entirely voluntary but based on demand or factors alike it is likely to have minor or non-existent beneficial effect on the health of the worker (Musick and Wilson 2003). In voluntary work ‘choice should remain central’ (Warburton 2006). If volunteering is based on free will and own choice, it is associated with a sense of control and therefore affects psychological well-being and physical health (see Graff 1991, Warburton 2006). Furthermore, among older adults formal but not informal social interaction (including volunteering and helping) improved mental health (Musick and Wilson 2003, Li and Ferraro 2005).

➤ *Non-stressful amount*

The results in some studies have suggested that the association between voluntary work and health (mortality) would be curvy linear, meaning that the possible positive effects of volunteer work on health would decrease after a certain threshold (Musick et al. 1999, Warburton 2006). In addition, volunteering is more flexible than paid employment. For instance, physical or mental illness or frailty can be a barrier to paid employment while volunteering can offer more flexibility in regard to working periods or working hours. In volunteering, disability or illness can be less stigmatizing and thus volunteering can be ‘a normalizing kind of experience’. There are also ‘Supported volunteering programs’ that offer supervision, training and support for volunteers with mental health problems. (Graff 1991.)

➤ *Other resources*

The health promoting effect of voluntary work has been found to be stronger among those who have better physical and mental health and more personal or other resources (e.g. are not living alone) (Musick et al. 1999, Thoits and Hewitt 2001). Furthermore, the effect of voluntary work may even be negative among those with fewer resources (see Warburton 2006).

➤ *Salience*

The type of volunteer work and the reasons to execute it should be taken into account when evaluating its impact on health. If volunteer work is done due to instrumental reasons its negative effect on depression and positive effect on health is smaller than if volunteer work is done because of 'its own sake'; the volunteers' role identity status is important in respect to the association of volunteer work and health (Oman et al. 1999, Van Willigen 2000, Musick and Wilson 2000, Greenfield and Marks 2004).

➤ *Provides a chance to carry on former roles*

If volunteer work can provide experiences that have brought self-respect in the former career – ongoing sense of usefulness – volunteering is likely to enhance life satisfaction (Stevens-Roseman 2006, see below the project 'The SESAM Academy' for the Netherlands).

➤ *Commitment*

The positive effects of volunteer work on life satisfaction, mental and perceived (general) health (of the older adults) are more likely to emerge if volunteer work is sustained over a longer period of time (Musick and Wilson 2003) or takes more hours (Morrow-Howell et al. 2003). However, many hours of constant volunteering may even deteriorate health (see above the non-stressful amount). In general, in regards to health, commitment to work and not the act of execute, is important.

➤ *Reciprocity*

Personal attachments among volunteers and between volunteers and paid staff may be an important factor affecting health (Graff 1991, Musick and Wilson 2003, Reynolds 2006, Warburton 2006, Stevens-Roseman 2006). Volunteering may also work as a generative response: it is a way to pay back to the community or pass own experience and knowledge to the younger generation (see Graff 1991, Warburton 2006 and a project 'Substitute grandparents' below).

2.3.3 Volunteering in the Member States

The level of volunteering varies between countries. However, such figures are highly vulnerable to methodological issues such as definition (whether activities in religious agencies, in non-official/registered associations, ad-hoc activities etc. are included or not) and data sources (for instance, whether figures are based on population ad-hoc or panel surveys, or information received directly from organizations) (see Hilger 2006).

There are only minor differences in activity between females and males. In many countries, where information was available, males were actually more active than females. This is contradictory to North America where females are clearly more active than males (Freedman 1999, Wilson 2000).

Volunteering patterns vary between countries. On average, more than one third of volunteers work in activities related to culture (in Finland this is sports dominated). For Finland, France, Germany and Italy volunteering in culture was above average. Almost as common is volunteering in organizations working in social and health sector. In Finland and Spain relatively greater proportion of volunteers are involved in civic activities and in Netherlands, Poland and Spain in education.

2.4 The impact of social capital on health

➤ Social capital as a collective good

Kawachi et al. (1999) make a distinction between social integration measured as an individual characteristic and social integration measured as a collective characteristic. In this perspective, they measured social capital in the US at state level. The social capital indicator is the extent of civic trust. It was assessed by responses to the item: "Generally speaking, would you say most people can be trusted?" Collective perceptions of reciprocity were tapped by the following item: "Would you say that most of the time people try to be helpful, or are they mostly looking out for themselves?" Membership in a wide variety of voluntary associations was also taken into account. He estimated the per capita membership of voluntary associations in each state.

The mechanisms by which social capital is influencing individual health on the neighbourhood level might be (1) the easier and faster diffusion on health information in cohesive communities (information on health enhancing practices, the availability of supporting services, etc.), (2) an increasing likelihood that healthy norms of physical behaviour are adopted (physical activity, eating out habits etc.), (3) Social control exerted over deviant health related behaviour (smoking, drinking in public etc.).

➤ Social capital and civic associations

Christoforou (2004) measured social capital in European countries by membership in civic associations. Being aware that the indicator "group membership" is relatively weak the outcomes of the study can be seen as a starting point for further research. An important conclusion from this empirical analysis is that both individual- and aggregate-level factors determine the individual's participatory behaviour. The author notes that in most countries of the EU, factors like education (positive) and unemployment (negative) have a strong impact on the probability of an individual to be a member of a group. Thus, expanding education and employment opportunities would apparently increase the incentive to participate in groups and enhance the stock of social capital.

➤ The link between social capital and health

Pevalin and Rose (2003) designed their study on social capital for the British NHS on a conceptual model that "levels of social capital may vary by broad structural factors and that social capital may either have its own direct effect on health or it may mediate or moderate the effects of the structural factors on health".

They concluded that social capital has positive effects on health but it does not mediate (and only moderates some of) the basic structural factors' effects on health. Sex, age, marital status, income, class, employment, education etc. are the factors which influence individuals' health status. One positive finding however that social participation (as one indicator for social capital) was completely moderated the effect of working status on health for working age women. In other words: those women being active in a societal group were not influenced by the negative impact of unemployment on health. Their final conclusion is, that "programmes or policies that encourage the development of individual social capital through involvement in the community may produce benefits for health but they will do little to negate the more fundamental inequalities in health" (Pevalin and Rose 2003).

The mechanisms linking social capital to health include notably availability of help for activities of daily life, psychological support, lower isolation and loneliness, information, etc. The connection between social capital and care is mostly established by proxies and Grammenos et al. (2005) conclude that social capital seems to have a positive correlation with access to informal care and a reduction in activity limitations for persons aged 65 and over.

McKenzie et al. (2002) see the potential of social capital in explaining partly different levels of mental health in different areas but reject the concept due to methodological shortcomings which however might be overcome in the future.

2.4 Conclusions

The different studies arrive at common conclusions concerning prevention, cognitive ageing and Alzheimer's disease.

- Activities (professional or otherwise) in old age have a direct impact on the formation and preservation of the cognitive reserve.
- Active ageing (remunerated work, community work, leisure activities, etc.) may be a significant factor in improving cognitive capacities and decreasing health costs.
- The positive effects are slightly greater for non-professional activities compared to professional activities.
- The main driving factor here, as in other dimensions of life, is educational attainment. Studying and learning are regarded as an efficient measure in developing one's cognitive functioning.
- The positive impact of professional activity suggests that if an individual would like to continue with his/her professional activities, there is no reason to prevent that person from doing his/her job but, in fact, every reason to promote this.
- The increased risk of depression in people who continue to work (in all likelihood, because they are forced to continue) means that there is no reason to prevent an elderly individual from stopping his/her professional activities insofar as (1) this is his/her choice, and (2) this is institutionally possible.
- It appears necessary to undertake a wide-ranging reflection process on how to develop and propose constructive activities for retired people (e.g., voluntary participation in charitable organizations, leisure activities, etc.).

Volunteer work, at best, bestows significant benefits on volunteers themselves:

- Volunteering provides positive experiences, decreases social isolation and enhances sense of control, self-esteem and good health.
- Volunteering contributes to clients, communities and society.
- Voluntary agencies can neither be a substitute to professional social and health services nor take responsibility to organize them.
- Volunteering favours the transfer of information, knowledge and experiences of the older persons to the next generations and immigrants.

Finally, social capital may:

- either have its own direct effect on health or it may moderate the effects of the structural factors on health.

- The mechanisms linking social capital to health include notably availability of help for activities of daily life, psychological support, lower isolation and loneliness, information, etc.

I.b.3. The impact of caring on health and social participation

3.1 Introduction

Family care can be defined as care provided by family members to family members. Family care is one of the crucial elements in care in all European countries (with a lesser degree in the Scandinavian countries).

Family care has an informal character as carers do usually neither have professional training nor receive a salary for their services and mostly do not define themselves as carers (Theobald 2005). Hence, family care also runs under the term informal care. Additionally, taking on caring responsibilities is usually not based on a conscious decision to become a carer, but rather on an event in the life of a close relative.

3.2 Family carers' health

Impacts on carers' health are complex and difficult to measure, the findings are often contradictory. Needs of and health impacts on elderly carers differ to a large extent from those of younger carers. Studies in the UK (Wenger 1990; Tinker et al. 1998 in: Carer of Elderly People- Summary of the Background Evidence) suggest that a high proportion of elderly informal carers are in poor health, but ask less likely for help from formal services.

Health status was measured by the question "In general, would you say your health is: 1 (excellent) to 5 (poor)?" Once again stability, i.e. no change, is the predominant result – at least for 5 countries with the mere exception of Greece. In 5 countries changes to the worse are more often than changes to the better. In Poland alone there are marginally more improvements than there is deterioration (see table I.13).

Taking up caring activities results in changes of carers' self assessed health status (Bien et al. 2006).

Table I.6: Change in the health status of carers from T1 to T2

	Negative change (% of carers)	No change (% of carers)	Positive change (% of carers)	Total
DE	28,2	60,2	11,6	100
SE	32,1	51,7	16,2	100
UK	29,5	52,2	18,4	100
PL	25,1	47,6	27,3	100
IT	29,1	54,2	16,7	100
EL	42,5	41,9	15,6	100

Source: Bien et al. 2006.

Even if not necessarily significant direct – and not self assessed – health impacts can occur. Those are physical strain and musculoskeletal problems (Carers of Elderly people Summary of the Background Evidence) as well as emotional strain. In addition care provision might have indirect effects on caregivers' health such as lower earnings or income which in turn are determinants for potential deterioration of health. In case of co residence housing conditions may worsen, especially if the care receiver moves into the same flat. Direct and indirect effects need to be mediated by coping measures of the carer.

On the other hand, a lot of carers reported positive effects on health, such as increased physical activity or mental well being. Physical and psychological support of the carer for the person in care is part of family carers' mental motivation in all European countries. Strong convictions with regard to the elderly (e.g. ensure dignity for the person in care, to allow them to stay at home as long as possible, etc.) help those carers to continue caring for the family member (Bien et al. 2006).

Studies present mixed results regarding reasons for negative health impact of carers. It seems that neither gender, age, the category of care nor co-residence has necessarily an impact on health. Some studies present also opposite effects such as better health and functioning for carers than for non carers (Pinquart and Sörensen 2007).

Multiple factors such as high level of care responsibility and care intensity were associated with lower levels of health (UK). But multivariate analysis taking into account additional independent variables did not confirm those results. Mixed results may be explained by carer self-selection and the presence of ex-carers in the non carer population.

The meta-analysis of Pinquart and Sörensen (2007) indicates that predictors for worse health of carers are a combination of factors such as the severity of behaviour problems of the care receiver, cognitive impairments, long term care perspective, co-residence, not being a spouse carer, higher caregiver burden and depression, higher age, lower socioeconomic status and lower level of informal support.

Pinquart and Sörensen (2007) conclude that care receivers cause stressors (physical impairment, cognitive impairment, behaviour problems) which not only negatively impact on physical health, but also, and to an even greater extent, mental health. However, cognitive impairment or behaviour problems of the person in care may lead to physical symptoms of the carer such as exhaustion, pain in arms and legs, heart trouble and more severe stomach pain than in the general population (Germany) (Meyer 2004). Reasons might be role conflicts and the feeling of not being able to provide adequate care. Other outcomes are behaviour changes of the carers such as difficulties to get enough sleep and/or the lack of healthy eating.

Difficult home care arrangements with long lasting mental and physical stress on both sides, may even lead to an escalation in physical or psychological violence if no professional support is received. This may affect the elderly person in care, but may happen also to the carer due to excessive demands on the carer and their focus on the person in need of care, as result from third persons, feeling of guilt as well as from verbal and physical abuse from the person in need of care.

The psychological impact of care is to a large extent presented in studies regardless of different conditions in different European Countries. In France, family carers have double the risk of depression than in the normal population. Higher percentages of carer depression occur also in Spain, Slovenia and Austria. Psychological effects are especially strong for spouses and persons providing more than 20 hours of care a week. Caring relationships of older couples may be also affected as the decease of the dependent partner can lead to a loss of the will to life and an actual deteriorating health of the remaining partner.

Tensions between person in care and the caregiver may have negative impact on the relationship, especially when sharing the same household and being available 24 hours a day. Carers have difficulties to relax and to recreate, and to get a distance to the person in care (and vice versa). Further, family care is often a full time job preventing the carers from social activities or from pursuing self affirmation in other activities which can lead to psychological problems.

3.3 Impact of informal care on social activities of carers

A general overview of the impact on care on the social activities of carers is difficult to obtain. Lucinda Platt (2006) studied the impact of long term illness, caring commitments, gender and ethnicity on the level of individual social participation for British citizens. Care was not broken down into different categories and does not only include long term-care and the sampled age group was only from 18-59. As variables for social engagement she measured (1) the reception of infrequent visits, (2) infrequent visiting of others, (3) infrequent going out and (4) contact with clubs. She concluded that carers have constraints on their social activity. This applies particularly to male carers. Increasing age is strengthening constraints. However, in both cases involvement in organised activities is not significantly affected. She suggests that “the existence of carers’ networks and support groups may already be providing an alternative form of social contact to the more informal visiting and being visited that they appear to miss out”.

Event though not systematically researched, the feeling of social isolation and the inability to participate in normal family and social life, as reported in Slovenia, Spain or Austria (Mestheneos and Triantafilou 2005)⁶⁷, is certainly a wider phenomenon in more European countries.

3.4 Conclusion and policy implications

The different studies agree that all European countries are expected to remain dependent on family care. This raises a certain number of questions, notably:

- There is a need to support family carers in order to reduce negative health impacts (physical and psychological health) as well as to improve health prevention for family carers.
- Difficult home care arrangements with long lasting mental and physical stress on both sides, may lead to an escalation in physical or psychological violence if no professional support is received.
- Family carers are not subject to health and safety regulations and in most countries do not receive medical and psychological support like formal carers.
- The existence of carers’ networks and support groups is providing an alternative form of social contact and advice.
- The feeling of social isolation by carers and the inability to participate in normal family and social life, is a wide phenomenon in several European countries

⁶⁷ Mestheneos and Triantafilou 2005

PART II

Statistical analysis

Introduction

We presented in Part I a review of the literature.

The previous chapter has revealed a certain number of fields which are important for policy initiatives. Consequently, in this part we try to establish the quantitative importance of these policy channels. Also, we try to identify countries which present a special interest.

This statistical analysis valorises the results of the European surveys, notably:

- LFS (notably 2002 ad hoc module on disability and 2005)
- SHARE (First wave 2004, release 2),
- SILC (2004, 2005) and its precursor the ECHP UDB (notably, 2001).

The statistical analysis will help to identify similarities and differences across Member States.

The statistical analysis covers generally people aged 55 to 65 years but due to statistical problems (small sampling), in certain cases we increase the extend of the age group. Previous research has stressed that this age group presents the highest potential for policies concerning participation on the labour market and social participation.

However, when we study the behaviour on the labour market, we prefer to focus on people aged 55 to 59 years. This enables us to overcome the impact of institutional factors (different retirement age across countries, etc.).

This part will help us to identify the specificities of certain Member States and to analyse further in the next part their policy characteristics.

For each theme, we present its quantitative importance for the EU and then we proceed at a quantitative analysis by country.

II.1. Health and labour market participation

1.1 Introduction

The review of the literature has shown that health status is one of the most important determinants of labour supply among older workers. Also, deterioration in health status results in early departure from the labour market and most individuals in bad health will stop working at an early stage (notably when they reach entitlement age for benefits) while individuals in good health will retire later.

In this chapter we will analyse the characteristics of people with chronic health problems and analyse the different factors which affect labour market participation.

Before to undertake this analysis, we will present some graphs describing the correlation between socio-economic factors and health. This will help us to understand better the relation between health and work.

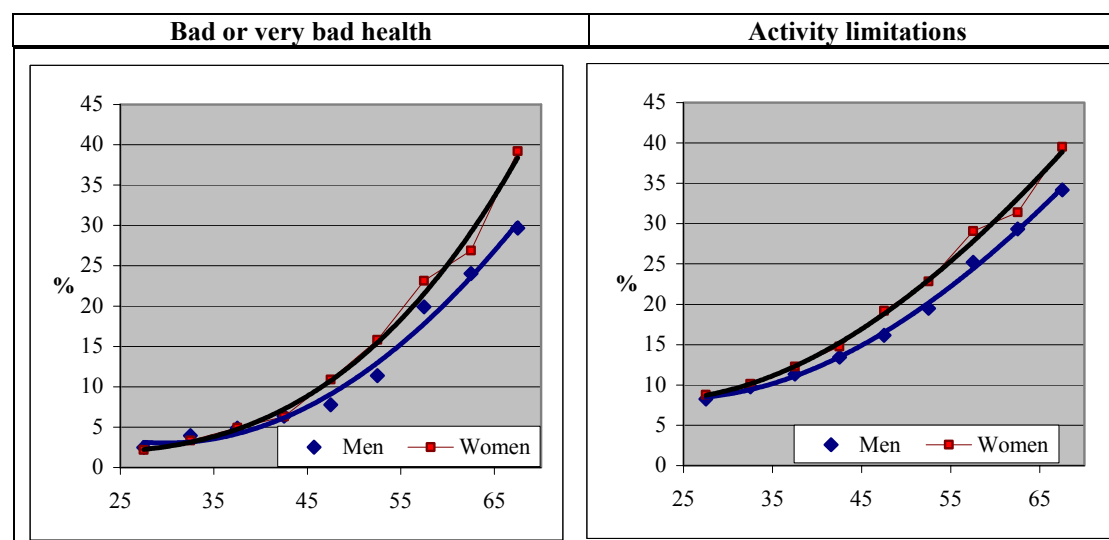
1.2. Factors affecting health and activity limitations

Descriptive analysis

As noted in Part I, different factors may affect health and activity limitations. Before to quantify the importance of each factor, we will present a descriptive analysis.

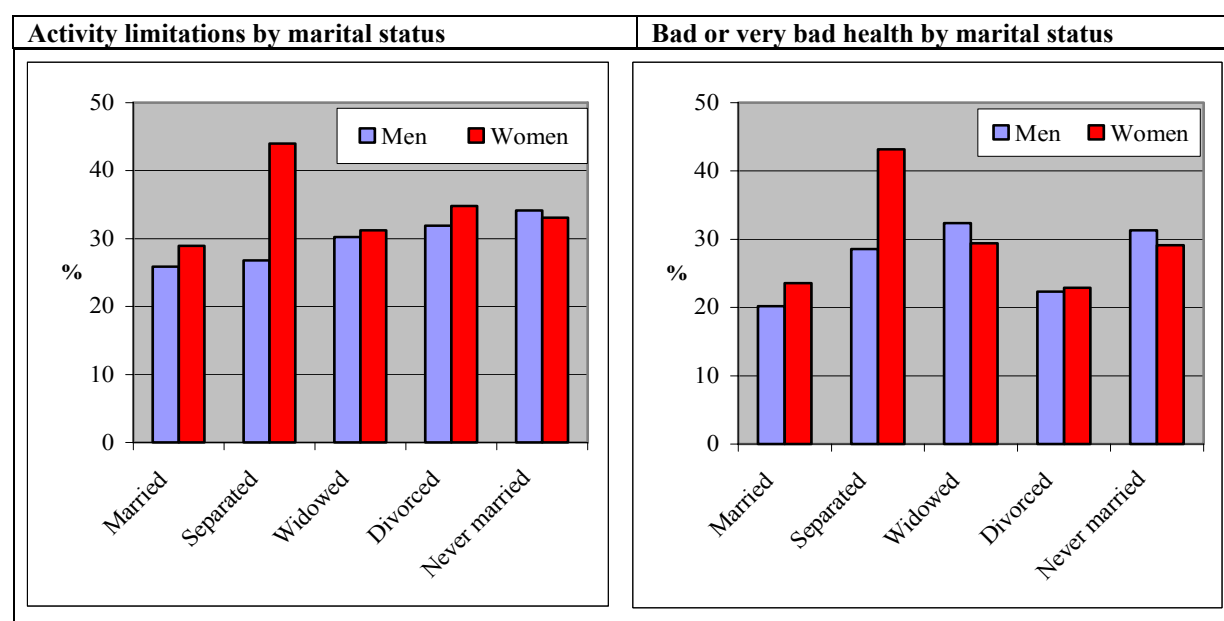
Age and gender are important factors affecting the prevalence of chronic illness and disability. The prevalence increases with age and a difference appears between men and women.

Figure II.1: Persons declaring bad health or activity limitations by age



Source: SILC 2004

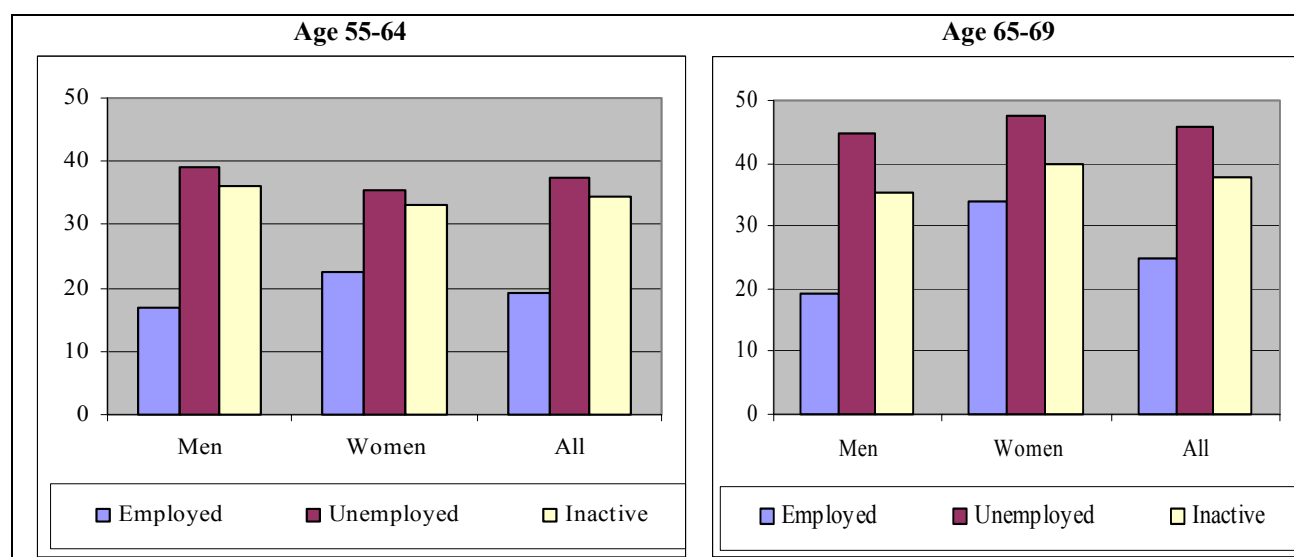
The marital status has been advanced as a socio-economic determinant. The following figure indicates that separated women constitute a group which needs specific attention.

Figure II.2: Persons aged 50-64 declaring:

Source: SILC 2004

As noted in the previous part, even if we assume that the heterogeneity (subjectivity) issue is absent, self-assessed longstanding health problems and disability might be biased by what is called the justification bias.

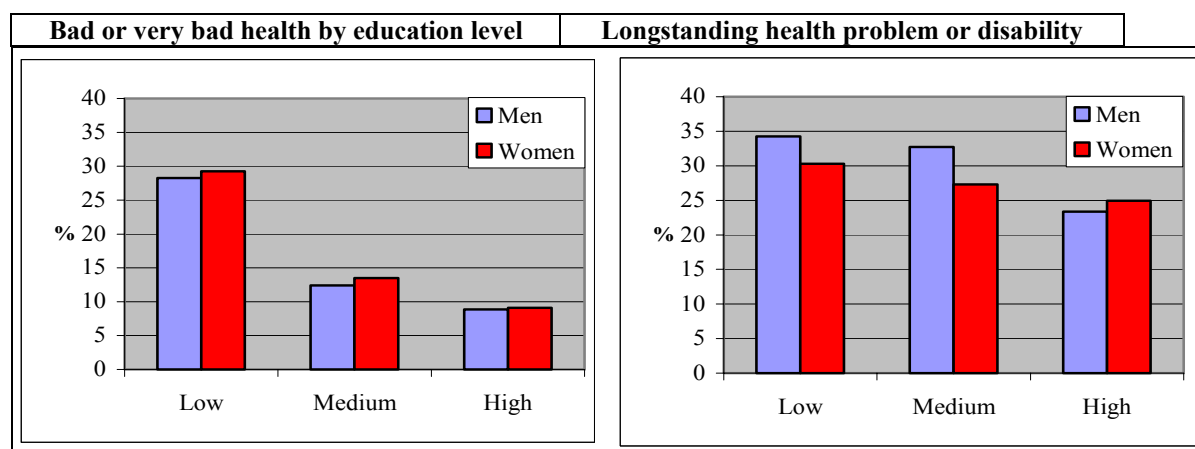
In order to reduce this bias, we present separately the results for people at working age (55-64) and people who generally are retired. We expect to have a small justification bias for this group. The data indicate that the difference between employed and unemployed/retired remains significant even for people aged 65-69. Differences between employed and unemployed/inactive seem to reflect real differences.

Figure II.3: Persons with activity limitations by sex and economic status.

Source: SILC 2004

As noted before, education might affect the probability of a chronic illness and disability through different channels. The data indicate a high prevalence of bad health and activity limitations among older people with low education.

Figure II.4: Persons aged 55-64 declaring:



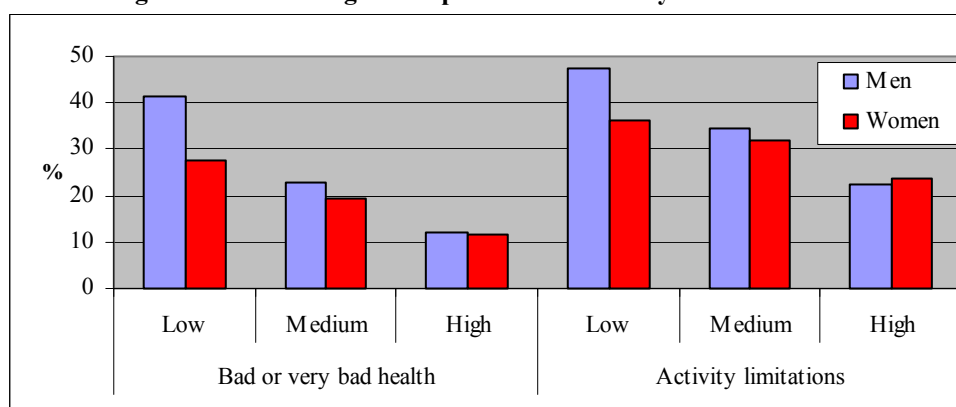
Note: SILC 2004 provides 30,5; 27,0 and 19,5% persons declaring activity limitations by education level for men and women. Source: SILC 2004 & LFS 2002 Ad hoc module

It is interesting to remember that, we have treated education as an exogenous factor affecting the prevalence of disability. Critics advance that education is an endogenous variable meaning that chronic illness and disability may affect the educational level.

An increase of income decreases the probability to report a longstanding health problems or disability. In the following figure we use relative.

Relative income has a significant impact on health and activity limitations. However, one has to keep in mind the two ways interaction between longstanding health problems and income.

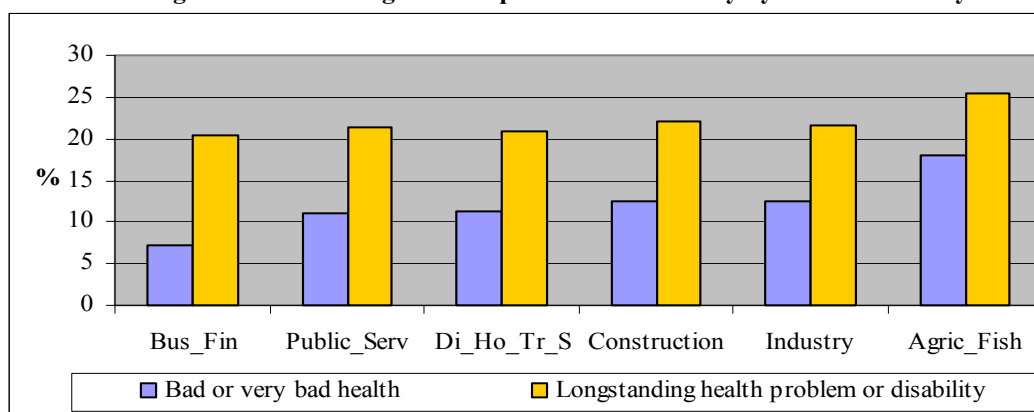
Figure II.5: Persons aged 55-64 declaring health problems or activity limitations



Low: if Relative income is less than 0,8; Medium: if Relative income is between $\geq 0,8$ and $< 1,2$; High: if Relative income is $\geq 1,2$. Source: SILC 2004

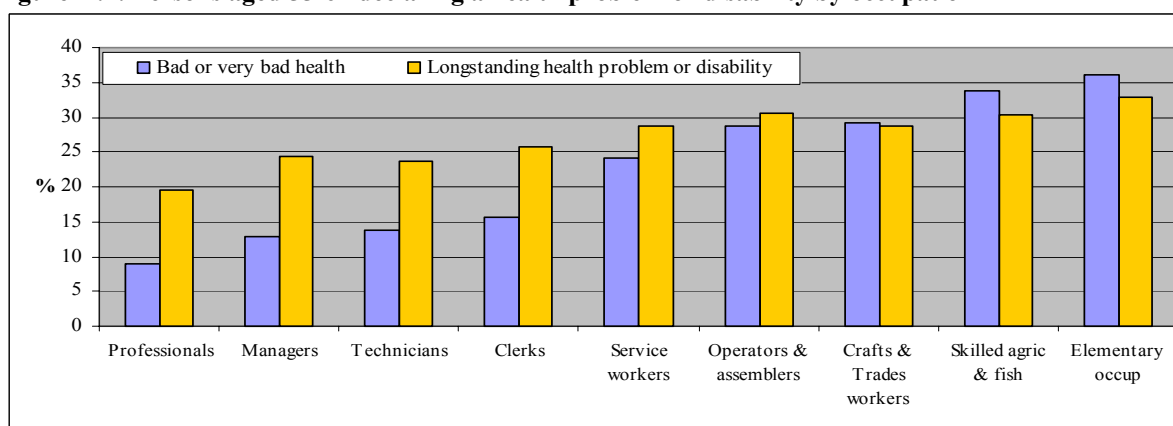
Working conditions play an important role. However, not all occupations or sectors present the same risks in terms of working conditions, occupational accidents and health hazards.

Unskilled and elementary occupations appear to be detrimental to health and activity limitations.

Figure II.6: Persons aged 55-64 declaring a health problem or disability by sector of activity

SILC 2004 & LFS 2002 Ad hoc module

Note: Bus_Fin: Business _ Finance; Public_Serv: Public services; Di_Ho_Tr_S: Distribution, Horeca, Transport, Services; Agric_Fish: Agriculture and Fishery

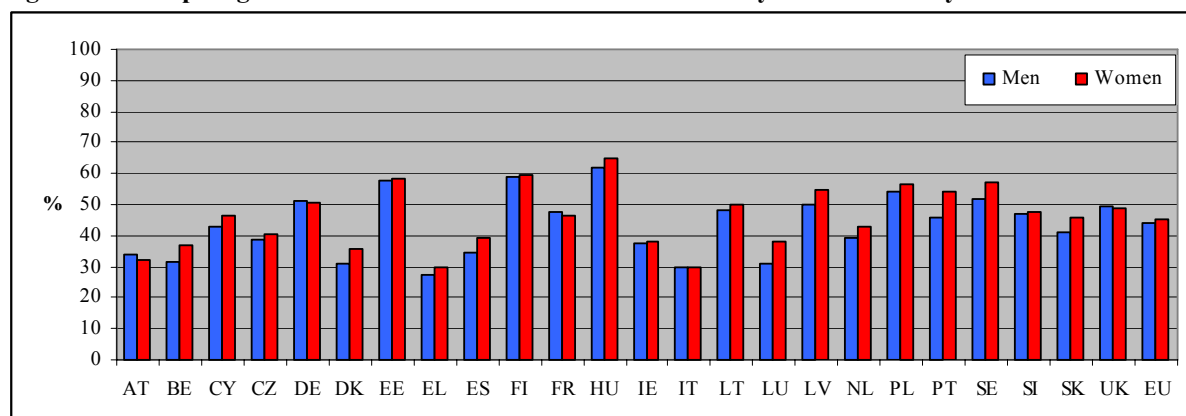
Figure II.7: Persons aged 55-64 declaring a health problem or disability by occupation

SILC 2004 & LFS 2002 Ad hoc module

Note: The results are similar if we use "Activity limitations" drawn from SILC 2004.

Analysis by country

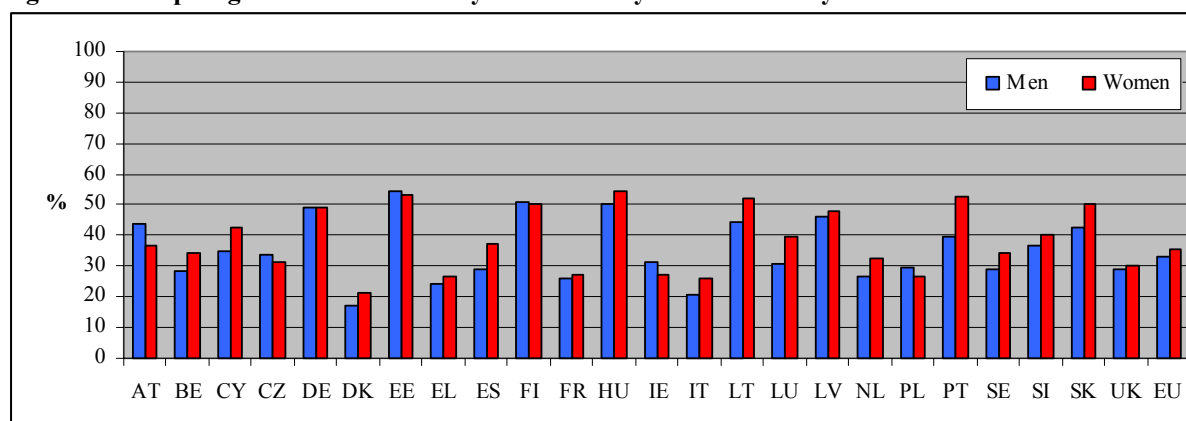
A first measure of health is the percentage of people who declare being in bad or very bad health. This percentage is relatively higher in the new Member States. However, a transitory health problem may not be a determinant characteristic to study long-term decisions. Furthermore, people with an activity limitation (e.g. missing fingers) may well declare be in good health and still have limitations concerning the nature of work they can do. Consequently, we consider that measures such as "people with a chronic illness or condition" and "people declaring activity limitations" seem to be more appropriate measures for the study of the relation between health and economic behaviour.

Figure II.8: People aged 55-64 with a chronic illness or condition by sex and country

Source: SILC 2005

In the following, we retain the broad “longstanding illness or condition” and the narrower definition “activity limitations” used in the SILC. The Labour Force Survey (LFS) Ad hoc module 2002 uses “longstanding health problem or disability”. This provides similar results as “longstanding illness or condition”. The term used also by the LFS “restricted in the kind of work ...” is too restrictive. It is closer to the philosophy of disability than to general health.

Generally, the prevalence of longstanding illness or condition is higher than activity limitations as some chronic illnesses might not lead to activity restrictions.

Figure II.9 People aged 55-64 with activity limitations by sex and country

Source: SILC 2005

Econometric analysis

We have discussed in detail the socio-economic factors affecting health in Part I. The SILC data enables us to study the impact of gender, education, marital status, occupation (previous for inactive) and relative income. We focus at people aged 25 and over in order to exploit a maximum of available information.

As noted above relative income and marital status pose the question of endogeneity (for example income may affect health and health may affect income). Consequently, the reported estimators for these variables might be biased.

For relative income, we have taken the equivalised household income (provided by SILC) and divided it by the national mean. A more intuitive measure of income is the poverty indicator. The risk of poverty threshold is 60% of the median equivalised household income. The risk of poverty increases the probability to report a longstanding illness or condition by 4%.

As expected lower education level, occupational level (current or previous) or relative income increases the probability to report a longstanding health problem or condition. Estimations for people with activity limitations provide similar results.

There is some evidence that the education of mother might affect the probability to report an activity limitation. However, the magnitude is low (less than 1% passing from one degree to another). This might be related to lifestyles.

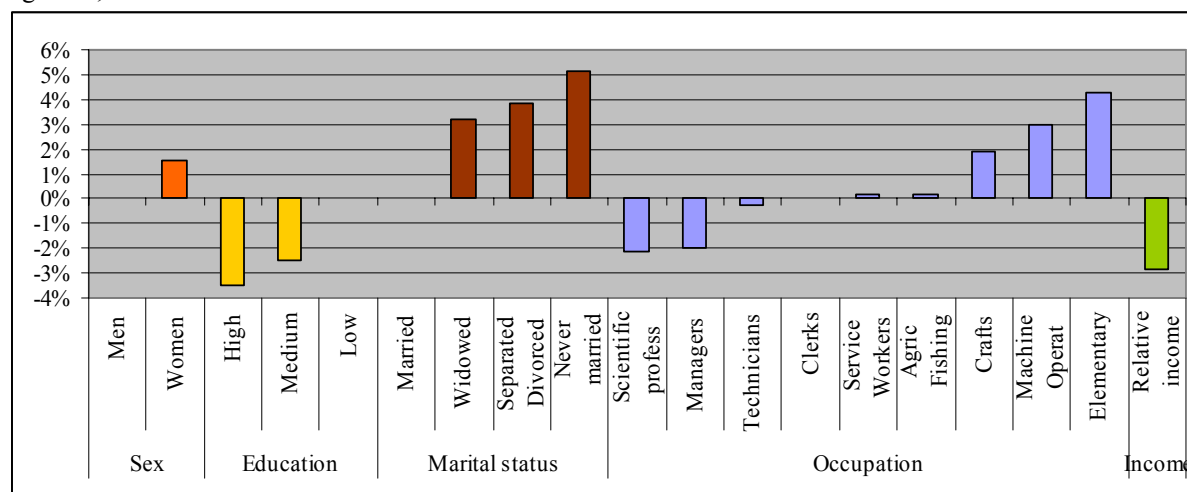
We did not include employment as an explanatory variable as it is correlated with income. Both raise the endogeneity problem. Certain consider that using employment reduces the endogeneity bias while others consider that by using employment we capture the justification bias⁶⁸.

Finally, as it was discussed at the beginning of this Part, age (in years) is a highly significant explanatory factor. We do not report it below as it is a numerical value in contrast to other variables which are binary qualitative variables (except relative income).

For the binary variables, the coefficient measures the increase in probability when we pass from the base state (sex: men, education: low education, marital status: married, occupation: clerks) to an alternative status. Concerning relative income our measure gives a coefficient measures the reduction of probability to report a longstanding illness when we increase relative income (the coefficient is close to the use of the binary “being” / “not being” at risk of poverty).

Figure II.10: Change of probability of reporting a longstanding illness or condition.

Age 25+; Probit estimation.



How to read: Variables with zero values are bases for comparison. For example, being woman increases the probability by about 1% in comparison to men. dF/dx is for discrete change of dummy variable from 0 to 1, except for relative household income which is a numerical value.

Probit: Number of observations: 269.692; Wald χ^2 (41) = 19.132; Pseudo R^2 = 0.13. Data source: SILC 2005. We have included dummies for countries. The estimation includes Island and Norway.

⁶⁸ Baldwin, Marjorie, and William G. Johnson. 1994. "Labor Market Discrimination Against Men with Disabilities." *Journal of Human Resources* 29(1):1-19. In alternative regressions with SILC 2004 data covering people aged 25-64, we takes into account the endogeneity of relative income. The explanatory variables for relative income are activity limitations, sex, age, experience, experience squared, education (1,2,3), economic status, company size, sector of activity, occupations, and dummies for countries. We used `cdsimeq` by STATA. The coefficient of activity limitations is not significant in this equation. The coefficient of relative income decreases in absolute terms but remains significant at 5%.

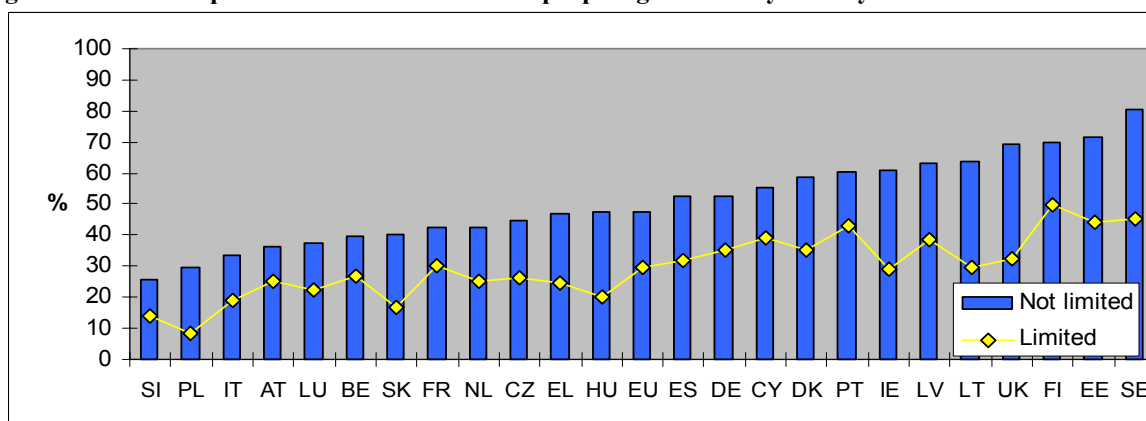
Mean values: Probability to report a longstanding health problem for the sample is 33% and the estimated by probit at mean values is 31%.

Significance: Non significant at 5%: Technicians, Service workers and Agricultural and Fishing workers.

1.3. Health and labour force participation

Generally, countries with a high overall Labour Force Participation have also a high Labour Force participation of people with an activity limitation. If we consider people with a longstanding health problem or disability, we find similar results. This means that overall general economic conditions play an important role for all groups.

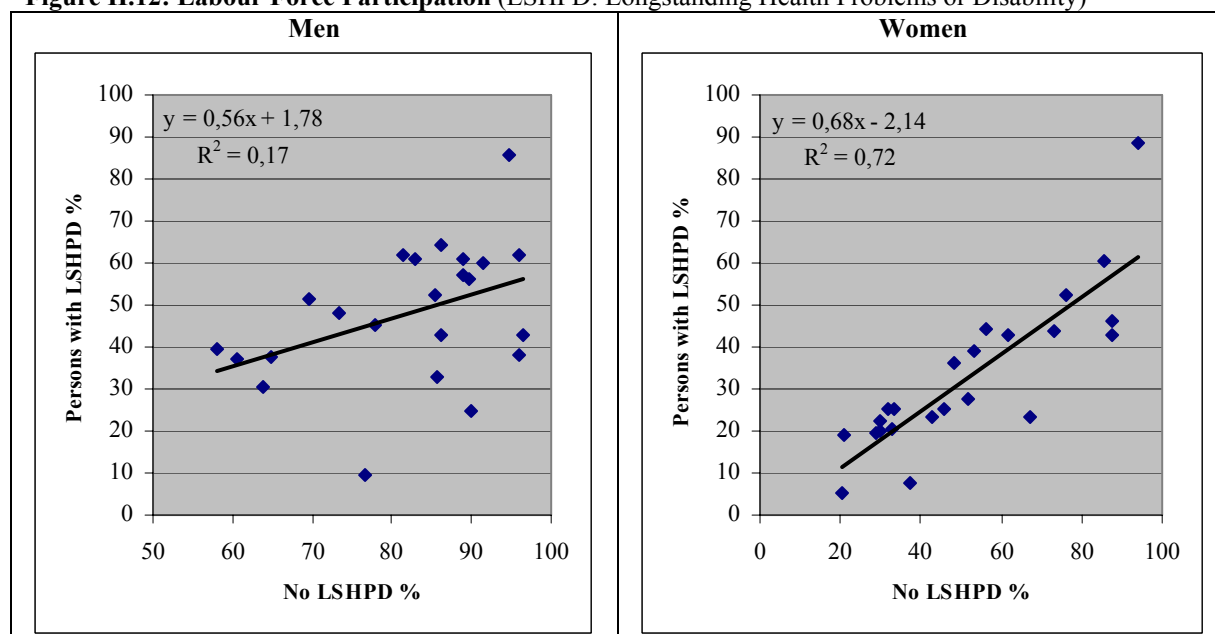
Figure II.11: Participation on the labour force of people aged 55-64 by activity limitation



Source: SILC 2005

However, it is important to notice that there is an important gender difference. General conditions seem to be more important for women than for men. The following figures indicate that the labour force participation of men with longstanding health problems or disability is weakly correlated with the participation rate of men without health problems. On the contrary, the correlation is very strong for women. This means that specific health factors exert an important impact on men's labour participation. On the contrary, for women health factors play a less important role.

Figure II.12: Labour Force Participation (LSHPD: Longstanding Health Problems or Disability)



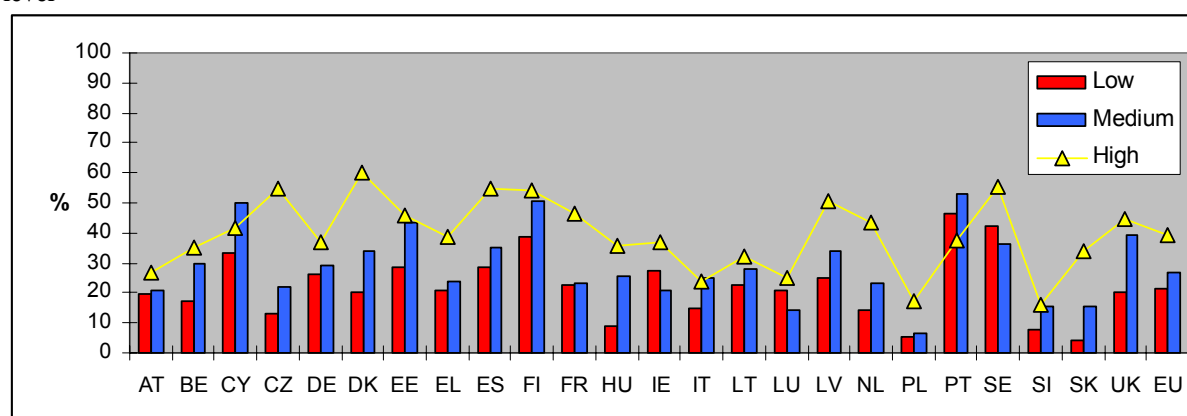
Note: Each point represents a country.
 Data source; LFS Ad hoc module 2002

This indicates that policies aiming to improve general labour force participation of women ought to affect significantly labour participation of women with longstanding health problems or disabilities. This is not true for men. Men with longstanding health problems or disabilities seem to require specific policies. One hypothesis is that work conditions affect differently men and women. For example, work accidents and occupational diseases concern mainly (80% of related annuities) men. Another hypothesis is that women with and without health problems have similar problems in terms of child rearing, etc.

Another interesting relation is education and labour force participation.

The following figure presents labour force participation of people with longstanding health problems or disability by education level. As expected, participation increases with education. Sweden and Finland appear as the best cases, as they experience high participation rates and no big differences across education levels.

Figure II.13: Labour Force Participation of persons aged 55-64 with an activity limitation by education level



Source: SILC 2005

Not all people participating in the labour force have a job. Below, we present the employment rate of people aged 55-64 with a chronic illness by sex.

Econometric analysis

The analysis of Part I has pinpointed several factors affecting labour force participation. In the following, we retain age (and age squared for non-linearity), education, experience, marital status, the presence of children, occupation (previous or current) wealth income (relative to the mean) and chronic illness (LSIC).

The probit estimations are generally better for men than for women. As similar studies, we find that a higher education and occupational skill increase the probability to participate on the labour market.

The presence of children is important for younger ages but not for older people (age 55-64).

It is important to note that the marital status is generally not significant for older people and never significant for people with longstanding illness or condition. This raises some questions on the quantitative importance of partner's status impact.

As noted in Part I, on the one hand health might affect labour participation and on the other hand work may affect health. In order to reduce this problem, we run separate regressions for people with and without longstanding or condition. We may note that experience has a relatively smaller positive

impact on labour participation for people with longstanding illness compared to people without longstanding health problem. Discrimination against people with health problems might explain this difference. Similar results are found for high education. Again discrimination might explain this difference. In both cases, the presence of discrimination means that the expected gains are lower for people with longstanding health problems compared to people without. Consequently, the incentive to participate will be lower.

Finally, when we enter health as a separate argument, we find a strong negative impact on labour participation. However, this coefficient might be biased upwards due to endogeneity (see discussion in Part I).

In summary, the level of education and work experience appear to be the most important factors for all groups.

Table II.14: Probability change to participate in the labour force
Probit estimates reporting probability change (1 corresponds to 100%)

	Age	Men				Women			
		55-64			25-64	55-64			25-64
		LSIC	No LSIC	All	All	LSIC	No LSIC	All	All
Age	Age	0,355 *	0,227 ns	0,307 **	0,035 **	-0,057 **	-0,088 **	-0,010 ns	0,088 **
	Age2	-0,004 **	-0,003 *	-0,003 **	-0,001 **	-	-	-0,001 ns	-0,001 **
Exper	Experience	0,013 **	0,006 **	0,010 **	0,006 **	0,009 **	0,011 **	0,010 **	0,016 **
Educa tion	Low	0	0	0	0	0	0	0	0
	Medium	0,032 ns	0,027 ns	0,034 *	0,012 **	-0,001 ns	0,040 ns	0,018 ns	0,071 **
	High	0,108 **	0,131 **	0,136 **	0,034 **	0,107 **	0,142 **	0,130 **	0,140 **
Marital status	Married	0	0	0	0	0	0	0	0
	Nev Mar	0,003 ns	0,049 ns	0,029 ns	-0,021 **	-0,027 ns	0,106 **	0,032 ns	0,126 **
	Widowed	0,000 ns	-0,074 ns	-0,046 ns	-0,025 *	-0,038 ns	0,014 ns	-0,014 ns	0,010 ns
	Sep Div	-0,028 ns	0,039 ns	0,010 ns	-0,008 ns	0,018 ns	0,133 **	0,074 **	0,112 **
Child	Child(ren)	0,068 **	0,065 **	0,073 **	0,029 **	0,012 ns	0,007 ns	0,009 ns	-0,102 **
	Serv Wor	0,085 ns	0,104 **	0,105 **	-0,001 ns	0,005 ns	0,086 **	0,046 *	-0,013 ns
Occupations	Clerks	0	0	0	0	0	0	0	0
	Crafts	0,008 ns	0,068 *	0,044 ns	0,002 ns	-0,092 **	-0,087 *	-0,092 **	-0,113 **
	Mach Op	0,02 ns	-0,018 ns	0,005 ns	0,004 ns	-0,072 *	-0,072 ns	-0,072 **	-0,074 **
	Technician	0,082 ns	0,076 *	0,081 **	0,019 **	0,008 ns	0,056 *	0,034 ns	0,023 **
	Element	0,159 **	0,222 **	0,212 **	0,029 **	0,037 ns	0,125 **	0,085 **	0,027 **
	Manager	0,162 **	0,194 **	0,196 **	0,033 **	0,066 ns	0,253 **	0,175 **	0,068 **
	Agr_Fish	0,119 *	0,268 **	0,233 **	0,044 **	0,054 ns	0,204 **	0,136 **	0,063 **
	Scien Prof	0,204 **	0,188 **	0,205 **	0,045 **	-0,011 ns	0,125 **	0,059 *	0,057 **
Wealth	Wealth Inc	0,002 *	0,000 ns	0,001 ns	0,000 ns	0,002 **	0,001 ns	0,001 *	0,000 ns
Health	LSIC	-	-	-0,185 **	-0,116 **	-	-	-0,116 **	-0,121 **
Labour force participation observed and predicted by probit (Level values)									
LFP	Observed	0,366	0,573	0,486	0,848	0,250	0,387	0,326	0,697
	Predicted	0,326	0,596	0,478	0,932	0,177	0,341	0,260	0,737

How to read the table: A change of education of people with a chronic illness aged 55-64 e.g. passing from low to high education increases the probability to participate on the labour market by 10,8% (0,108). dF/dx is for discrete change of dummy variable from 0 to 1 (Education, Marital status, Child(ren), Occupation and LSIC). Age and Experience are expressed in years. Wealth income is the total of interests and rents divided by the national mean. Dummies for countries not reported here.

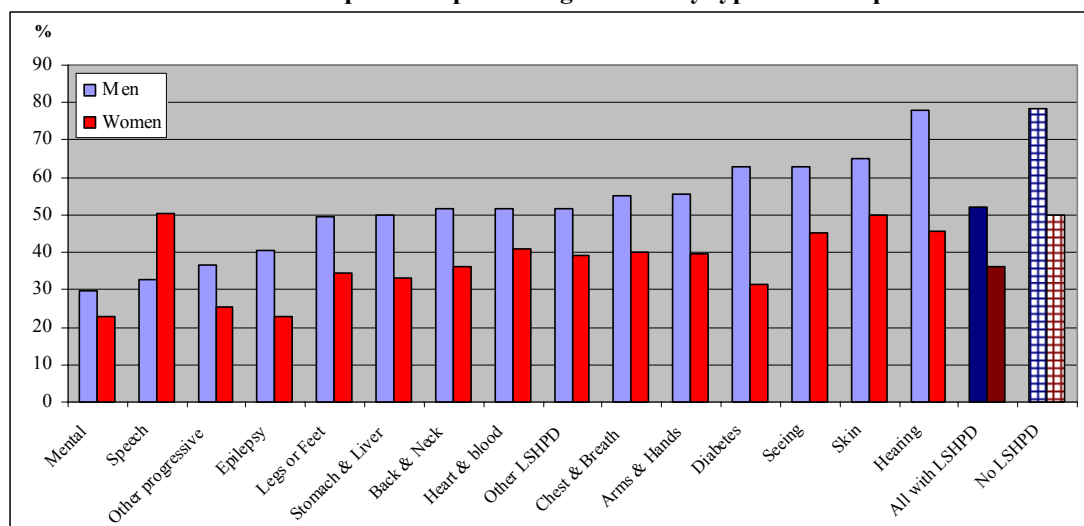
**: Significant at 1%; *: Significant at 5%.

LSIC: Longstanding illness or condition.

The nature of chronic illness

The Labour Force Survey 2002 is accompanied by an Ad hoc module on longstanding health problems and disability. The following figure indicates that people with mental health problems and progressive illness have the lowest participation rates on the labour market.

Figure II.15: Labour Force Participation of persons aged 55-59 by type of health problem or disability



Notes: LSHPD: Longstanding health problem or disability

The LFS presents: 01.Arms or Hands; 02.Legs or Feet; 03.Back or Neck; 04.Difficulty seeing; 05.Difficulty hearing; 06.Speech impediment; 07.Skin conditions; 08.Chest or Breathing prob.; 09.Heart, blood or circulation prob.; 10.Stomach, Liver or Digestive prob.; 11.Diabetes; 12.Epilepsy; 13.Mental, Nervous or Emotional prob.; 14.Other progressive illness; 15.Other LSHPD; 16. No LSHPD (Longstanding health problem and disability).

Source; LFS Ad hoc module 2002

The results provided by SHARE are similar, although the classification of chronic illness is different.

For information, cerebrovascular accidents in particular affect individuals' capacity to participate in the labour market, with only 28.1% of men and 21.6% of women in employment. Moreover, 42.1% of men and 33.8% of women affected by cardiac disease are in employment, (compared to 62.6% and 42.8% respectively for the European population of 50 to 65 year olds).

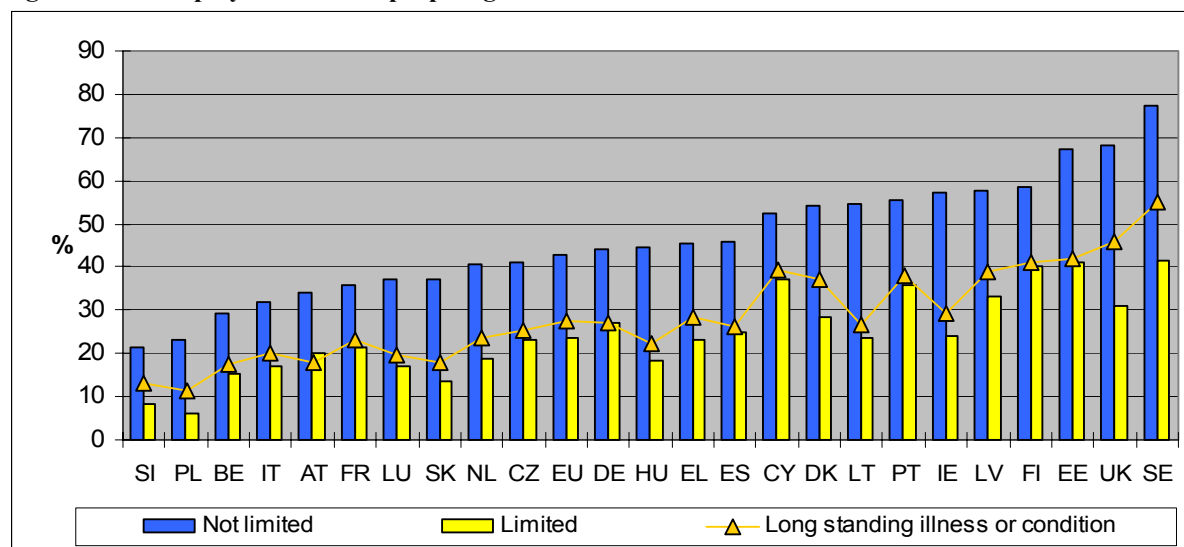
It is necessary to control for the other socioeconomic variables (age, education level and marital status) in order to carry out a more detailed analysis of the interrelation between cerebrovascular accidents and employment rates of older persons in Europe.

The results indicate that, self-reporting a cerebrovascular accident reduces the probability of being in employment by 21 points for men (17 for women) compared to those not declaring this, after controlling for age, education level and marital status. Similarly, reporting a cardiac disease reduces the probability of being in work by 9 points for men (11 for women) compared to those reporting no such disease, all other things being equal. Cerebrovascular accidents have the most significant impact on the employment of older persons, for both men and women.

Employment rates

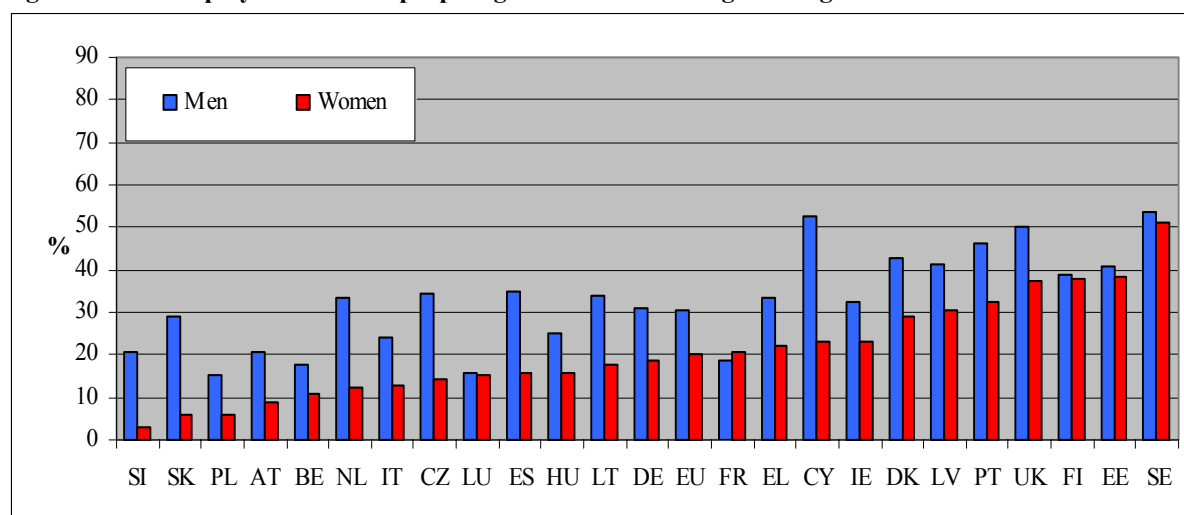
Several European countries⁶⁹ had already in 2005 met the Lisbon-Stockholm conference objective of 50% of 55 to 64 year olds in employment by 2010. On the other hand the employment rate of older persons in France, Italy, Austria, Belgium, Poland and Slovenia was below 30%.

Figure II.16: Employment rate of people aged 55-64 in 2005



Note: The Lisbon objective of 50% refers to all people aged 55-64. LFS 2005 III gives 9 MS meeting the Lisbon-Stockholm objective (excluding military). Source: SILC 2005 (ranked by employment rate).

Figure III.17: Employment rate of people aged 55-64 with a longstanding illness or condition



Note: Ranked by women's employment rate.

The Lisbon objective of 50% refers to all people aged 55-64. Here we report only people with longstanding illness or condition.

Source: SILC 2005

There is no correlation between the prevalence of longstanding illness or condition and labour force participation across countries. A deeper analysis of the level and progression of prevalence by age⁷⁰ indicates a weak relation which is sensitive to outliers.

⁶⁹ LFS 2005 gives 9 MS meeting the Lisbon-Stockholm objective (excluding military).

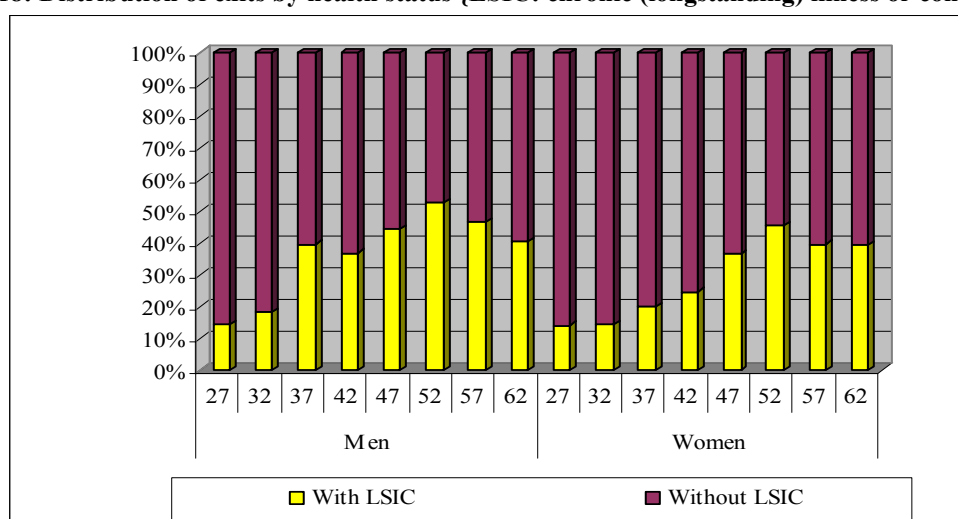
1.4 Health and movements in and out of the labour force

1.4.1 Importance of chronic (longstanding) illness or condition

People who exit the labour force report a higher prevalence of chronic (longstanding) illness or condition compared to those who stay in the labour force. Also, people with a longstanding illness or condition (LSIC) have a relatively high share of exits from the labour market while they are less numerous in the population.

Exits increase with age but after 55/60 we observe a change in the direction. This might result from the fact that people with chronic illness or condition might take early or normal retirement after the age of 55/60.

Figure II.18: Distribution of exits by health status {LSIC: chronic (longstanding) illness or condition}



Source: SILC 2005

1.4.2 Evolution by health status and sex

We focus on people entering or exiting the labour force. At the age group of 25-29, about 50% of movements in and out of the labour force concern exits (similarly 50% concern entries). At the age group of 60-64, about 90% of movements in and out of the labour market concern exits (and only 10% concern entries). The proportion of exits is a little higher for people with longstanding illness or condition compared to other people.

Concerning gender differences, women between the age of 40 and 45 are relatively more numerous to (re) enter the labour force. Probably, this is due to the end of restrictions concerning child rearing.

Concerning movements by education level⁷¹, we find that a higher level of education means relatively more entries (and consequently less exits) from the labour market. This relation is stronger for people without longstanding health problem or condition and flatter for people with a longstanding health problem or condition. This is similar to the econometric results discussed before in the section on

⁷⁰ $\ln(\pi/(1-\pi)) = \alpha + \beta \times \text{age} + e$; where π is the probability of longstanding illness or condition. ' α ' measures a level effect and ' β ' the progressivity. The country estimators for ' α ' and ' β ' are weakly correlated to labour force participation but strongly related to poverty indicators ($R^2=0,5$).

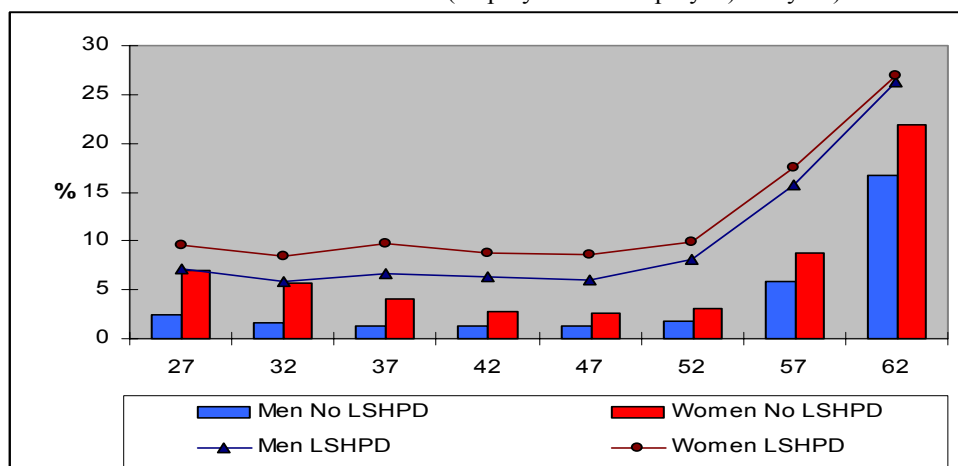
⁷¹ The results refer to people aged 25-64 because we have too few observations for certain educational levels for the age group 55-64. However, the results are similar for this latter age group. If we use Health (Bad or very bad and good or very good), we have similar results. The number of inactive older persons who (re) enter the labour force is small.

labour force participation. The impact of education is weaker for people with chronic illness compared to people without.

Concerning movements by marital status⁷², we may note that separated people have a relatively high rate of entries compared to exits into the labour market (both for people with and without chronic illness or condition). Apparently, financial constraints might push inactive parents of monoparental families to (re) enter the labour force after separation. As noted in Part I, people who return to work are more likely to be female, to have children, and to be financially supporting dependents.

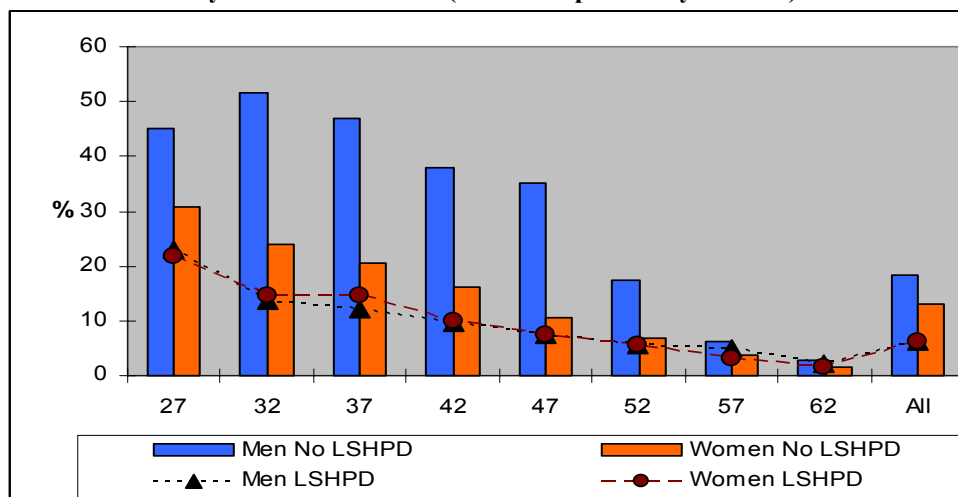
The previous data refer to the distribution of entries and exits from the labour market. In the following figure, we present the number of exits as a proportion of people previously active on the labour market. This gives a better idea of their quantitative importance. In the following figures, we present the results of the LFS Ad hoc module data. The sample of the LFS is larger compared to the SILC. Also, the LFS presents other important characteristics which will be presented below.

Figure II.19: Percent of exit from the labour force (As a % of previously active)
(% who have left labour force and who were active (employed or unemployed) last year)



Note: The ECHP 2001 provides similar results. In this case we retained people in bad or very bad health.
Source: LFS Ad hoc module 2002

Figure II.20: Percent of entry in the labour force (As a % of previously inactive)



Note: The ECHP 2001 provides similar results. In this case we retained people in bad or very bad health.
Source: LFS Ad hoc module 2002

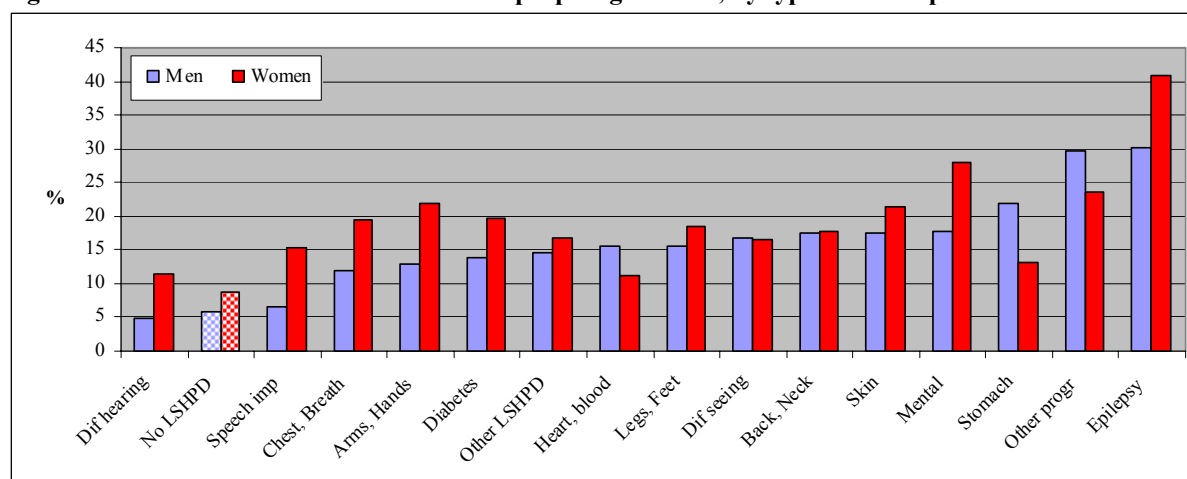
⁷² The results refer to people aged 25-64 because we have too few observations for certain marital status for the age group 55-64. However, the results are similar for this latter age group.

Concerning the type of occupation, we may note that crafts & trades and plant operators have the highest exit rates.

1.4.3 Type of health problem

In order to analyse the characteristics by type of chronic illness, we use the results of the LFS Ad hoc module 2002 which provides relevant information but is relatively old. We focus on people aged 55 to 59 years in order to avoid the impact of institutional factors (e.g. early retirement schemes and legal retirement age) on labour market movements.

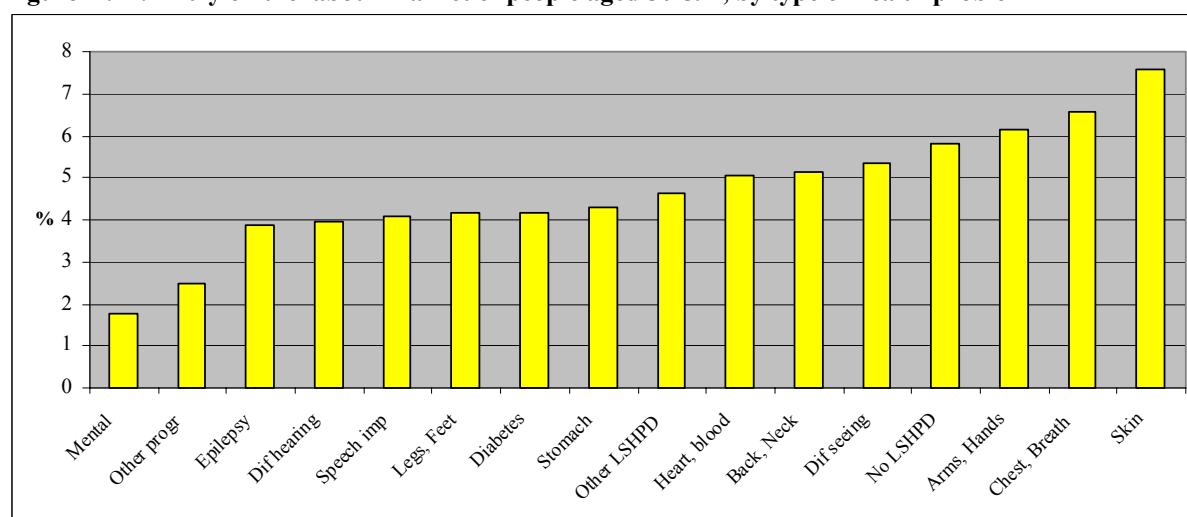
Figure II.21: Exit from the labour market of people aged 55-59, by type of health problem



LFS distinguishes: 01.Arms or Hands; 02.Legs or Feet; 03.Back or Neck; 04.Difficulty seeing; 05.Difficulty hearing; 06.Speech impediment; 07.Skin conditions; 08.Chest or Breathing prob.; 09.Heart, blood or circulation prob.; 10.Stomach, Liver or Digestive prob.; 11.Diabetes; 12.Epilepsy; 13.Mental, Nervous or Emotional prob.; 14.Other progressive illness; 15.Other LSHPD; 16. No LSHPD (Longstanding health problem and disability).

Source: LFS Ad hoc module 2002

Figure II.22: Entry on the labour market of people aged 50-59*, by type of health problem



* Age group: 50-59 as the group 55-59 is small.

Note: see the note of previous table concerning the type of health problem.

Source: LFS Ad hoc module 2002

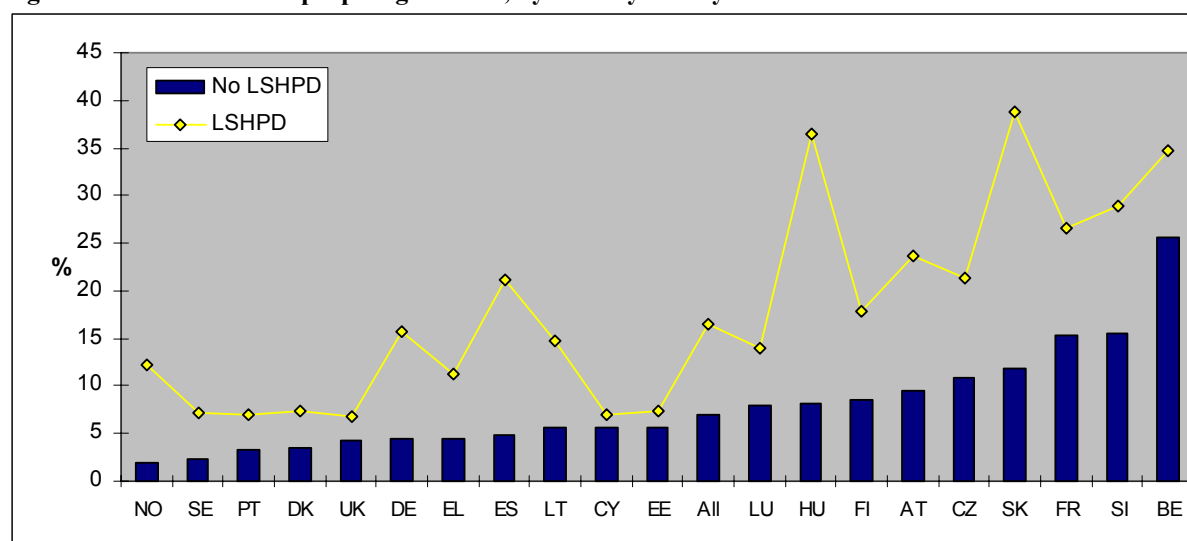
As noted earlier, people with mental health problems and “other progressive illness” constitute the most vulnerable groups. The exit rate of this group is relatively high and the (re) entry rate is low.

1.4.4 Analysis by country

In order to analyse the situation by country, we use the results of the LFS Ad hoc module 2002 which provides more observations but is relatively older. Exit from the labour force means a movement from employment or unemployment to inactivity.

Concerning all people, exit is relatively high in Belgium, Slovenia and France. On the other hand, the exit rate is low for Norway, Sweden, Portugal, Denmark the UK and Germany. Concerning people with longstanding health problems or disability the exit rate is relatively high in Norway, Spain and Hungary.

Figure II.23: Exit rates of people aged 55-59, by country and by health status



LSHPD: Longstanding health problem or disability

Age group: We focus on people aged 55 to 59 years in order to avoid the impact of institutional factors (e.g. early retirement schemes) on labour market movements.

Note: The ECHP 2001 presents different exit rates for people with bad/very bad health, notably for FI DK and UK

Source: LFS Ad hoc module 2002

As noted above, education is an important factor. The survey indicates that on average about 21% of people with low education and longstanding health problem aged 55-59 leave the labour force (compared to 9% for others).

More important, the data indicates that 45% of people with a longstanding health problem who were unemployed last year aged 50-59 leave the labour force (26% for others)⁷³.

1.4.5 Econometric analysis

In order to control different factors simultaneously, we have run probit estimations using as explanatory variables for exit from the labour force: sex (base: men), age, education (base: Low), marital status (base: married), occupation (base: clerks), sector (base: industry) and health (base: no longstanding health problem or disability).

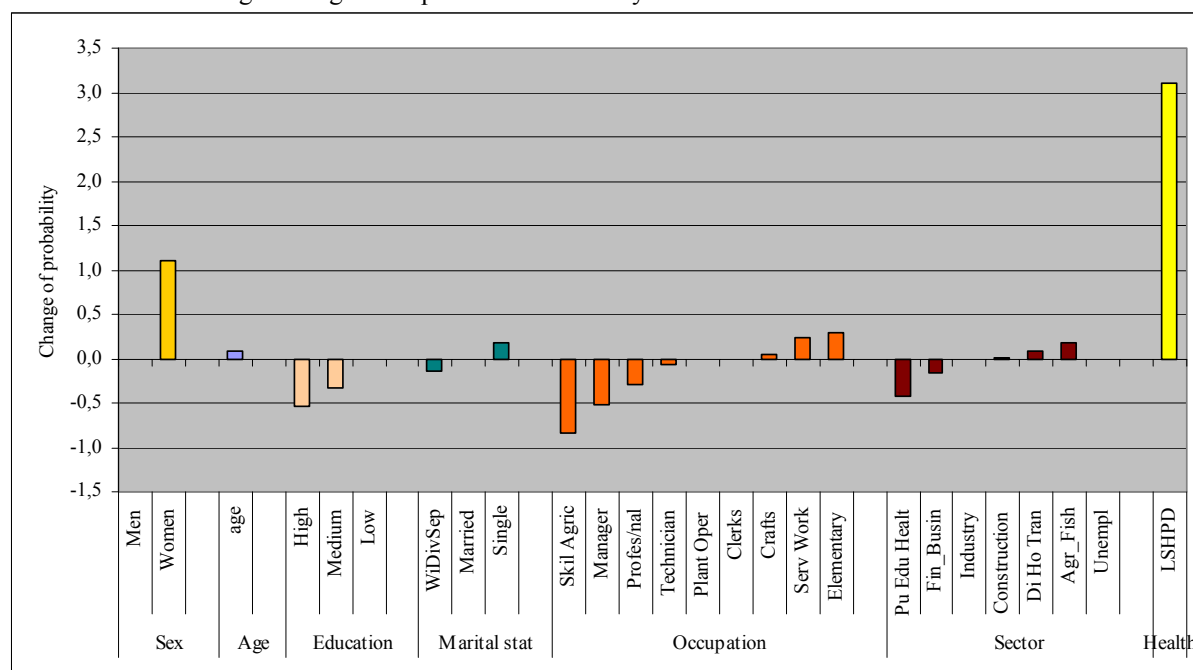
We retain 418.658 persons aged 25-64 (17 countries) for which we have all relevant information. If a person was employed or unemployed last year and now he is not participating in the labour force, we note exit (=1).

⁷³ We have widened the age group in order to avoid sampling problems. However we get similar results for the age group 55-59.

The results indicate that health and education/occupation are the most important factors affecting exits from the labour market.

Figure II.24: Change of exit probabilities by main characteristic

LSHPD: Longstanding health problem or disability



Data used: LFS Ad hoc module 2002. Number of observations: 418.658 persons in 17 countries. Dummies for countries not reported here. Probability of the sample: 3%. Exit from the labour force means a movement from employment or unemployment to inactivity.

Change of probability (dF/dx) is for discrete change of dummy variable to 1. Sex (base: men), age (numerical), education (base: Low), marital status (base: married), occupation (base: clerks), sector (base: industry) and health (base: no longstanding health problem or disability). Unemployed are included in order to take into account people previously unemployed who left the labour market. Aggregations have been operated for certain variables in order to avoid multicollinearities and problems related to few observations.

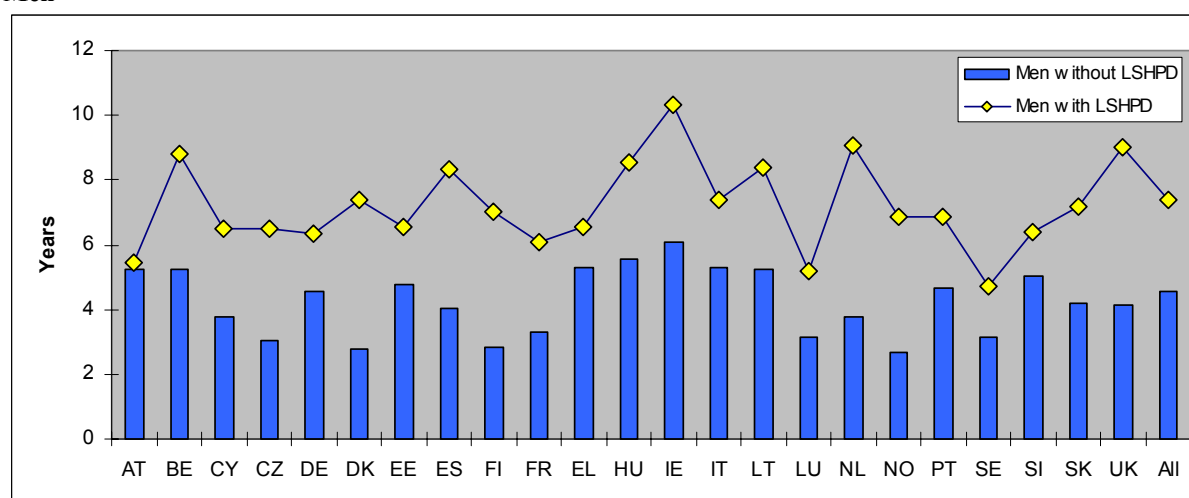
1.4.6 The time dimension or why assisting older workers is too late

From the previous analysis it appears that health and education are the most important factors affecting exits and entries in the labour force. Improving education and health favours (re) entries and decrease exits. The first suggestion which comes in mind is to provide adaptations for health and training for low educated.

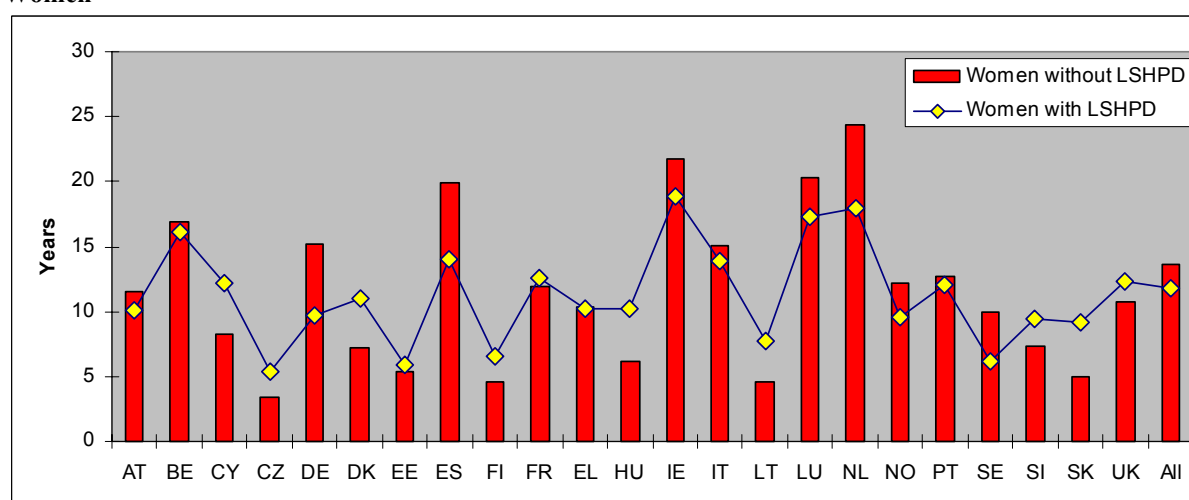
The question is what ought to be the target in terms of age-group. The LFS provides information on the time (in months) since the person last worked.

Figure II.25: Years since last worked; by type of health status; age group: 55-59

Persons not in employment but who have worked in the past

Men

Source: LFS Ad hoc module 2002

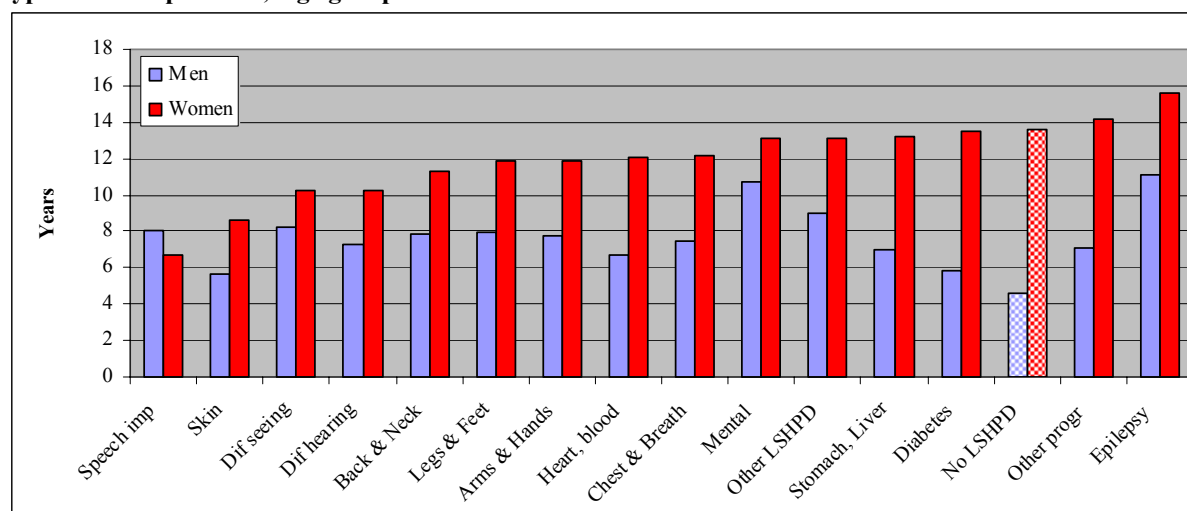
Women

Source: LFS Ad hoc module 2002

It appears that the number of years since persons with a longstanding health problem or disability (not in employment) last worked is about 7 years for men and 12 for women. This raises a serious problem of the value of their (past) skills.

The number of years is significantly higher for women. Also, certain types of health problems, notably progressive illness and diabetes, present a significantly different weight among men and women.

Figure II.26: Persons not in employment but who have worked in the past: Years since last worked; by type of health problem; Age group: 55-59



Note: LFS distinguishes: 01.Arms or Hands; 02.Legs or Feet; 03.Back or Neck; 04.Difficulty seeing; 05.Difficulty hearing; 06.Speech impediment; 07.Skin conditions; 08.Chest or Breathing prob.; 09.Heart, blood or circulation prob.; 10.Stomach, Liver or Digestive prob.; 11.Diabetes; 12.Epilepsy; 13.Mental, Nervous or Emotional prob.; 14.Other progressive illness; 15.Other LSHPD; 16. No LSHPD (Longstanding health problem and disability).

Source: LFS Ad hoc module 2002

The previous discouraging results are further reinforced by a lack of continuous training.

It is argued that the approaching of legal retirement age modifies the behaviour of older workers and employers. When one is approaching legal retirement age has little incentives to invest (e.g. in training) as the time horizon is short. On the other hand, the employer has little incentives to invest (provide training) to older people. This disincentive might be even higher for people with longstanding health problems or disability, due to discrimination.

Countries with high labour participation rates ((Sweden, Norway, Finland and Denmark) are also the ones with high training activities for older workers (except Portugal and Estonia).

The level of training participation increases with educational level. This implies that people with low education are disadvantaged and this is further reinforced by non-participation on training activities.

Consequently relevant policies ought to target people at younger age groups. They ought to prevent marginalisation instead of tackling it once it appears at an advanced age.

1.5 Health and retirement

1.5.1 The importance of health

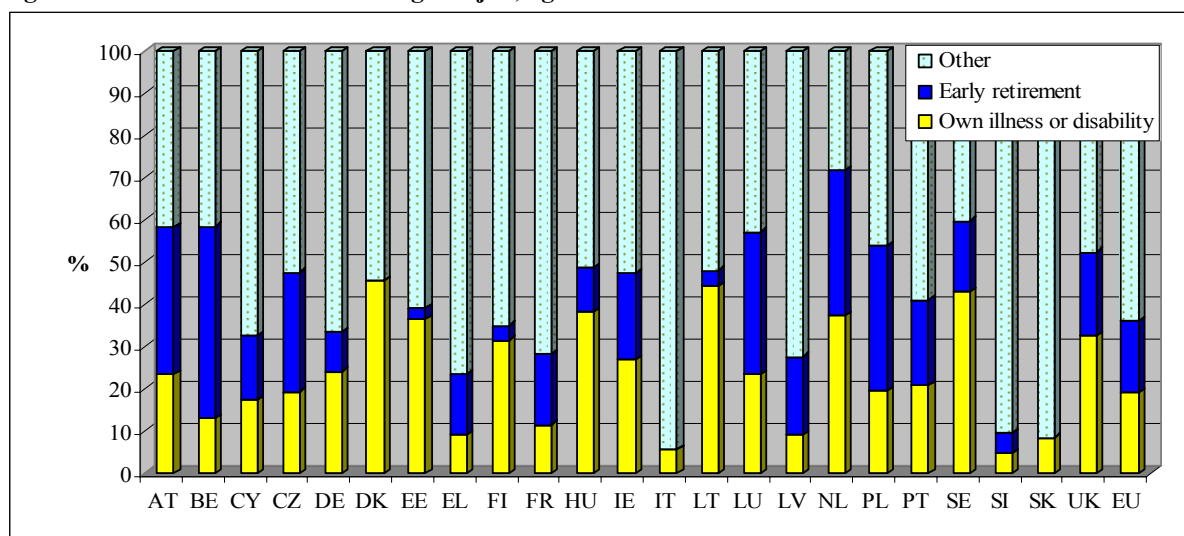
The Labour Force Survey (2005) presents the main reason for leaving last job or business. It distinguishes: dismissal, limited duration job, personal or family responsibilities, own illness or disability, education or training, early retirement, normal retirement, other reasons.

Leaving last job does not mean automatically retiring but is indicative of some personal factors influencing retirement decision, notably health.

Illness and disability are important reasons for leaving last job for people aged 55-59. We can say that a certain number of people who retire due to early retirement might also have health problems. Illness and disability decline latter due to an increase of early retirement and normal retirement.

The reader has to take into account that “reason” and pathway used may be different.

Figure II.27: Main reason for leaving last job, age 55-59

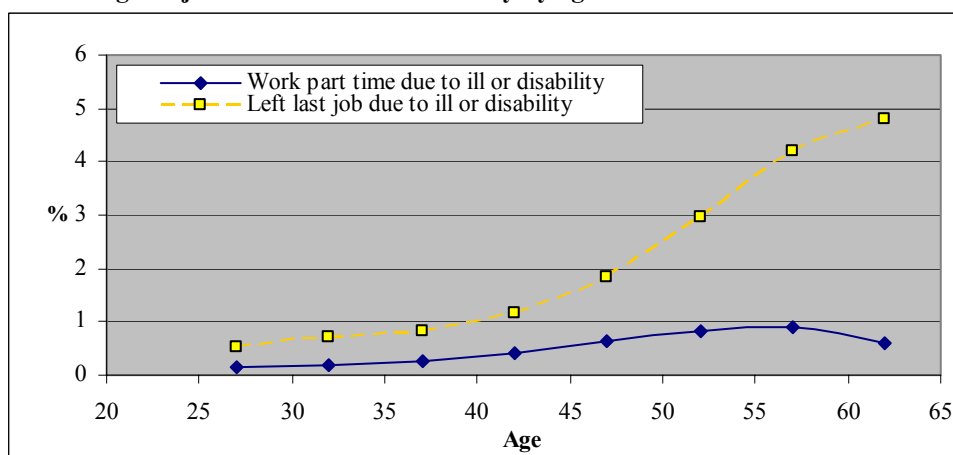


Source: LFS 2005

These results are in conformity with certain studies, discussed in Part I, which find that health problems (functional limitations and circulatory disorders) influence retirement plans more strongly than do economic variables.

In order to assess the magnitude in terms of the labour force, we retain all people who at a moment had a job. Consequently, we exclude people who never worked. This gives a better idea of the growth potential of labour force. Illness or disability constitutes an important factor for older age groups.

Figure II.28: Leaving last job due to illness or disability by age

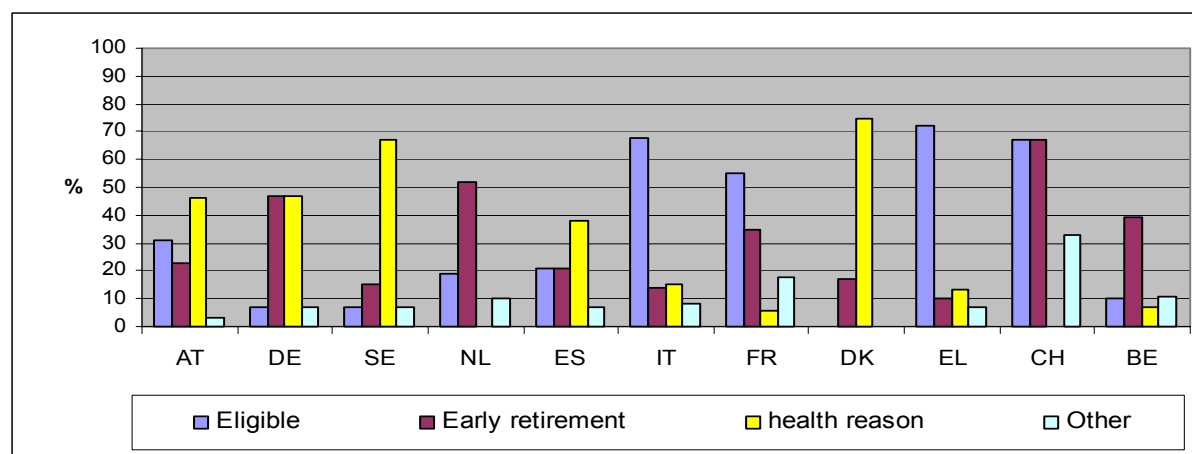


Notes: The base is people who at a moment had a job. It does not include disabled who have a FT job.

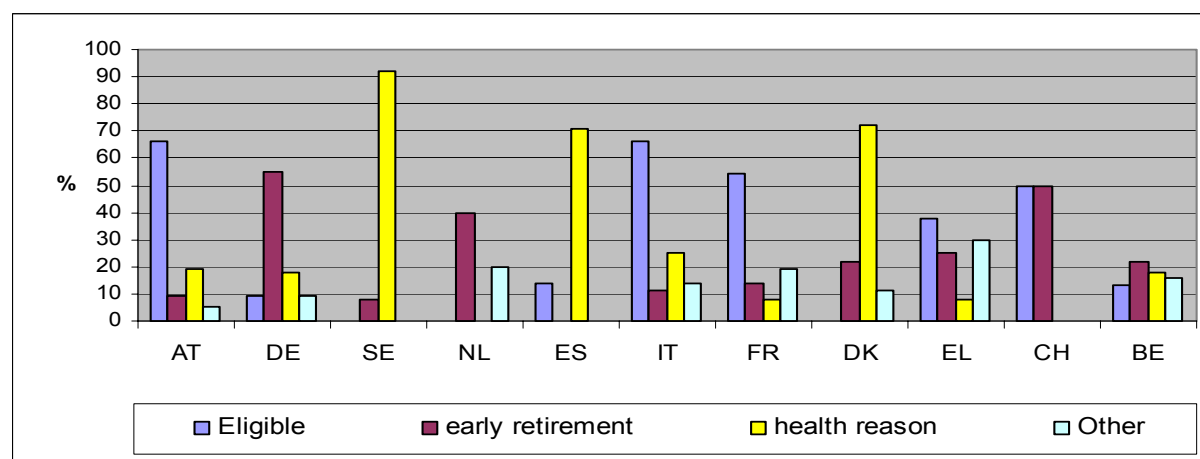
Source: LFS 2005

The SHARE survey provides information on reasons for retirement. A person may give several answers. Health again plays an important role.

Figure II.29: Reasons for Retirement by Sex and Country; age group: 55-59
Men



Women



Note: A person may give several answers. SHARE question is: For which reasons did you retire? 1. Became eligible for public pension; 2. Became eligible for private occupational pension; 3. Became eligible for a private pension; 4. Was offered an early retirement option/window (with special incentives or bonus); 5. Made redundant (for example pre-retirement); 6. Own ill health; 7. Ill health of relative or friend; 8. To retire at same time as spouse or partner; 9. To spend more time with family; 10. To enjoy life.

Source: SHARE 2005

1.6 Working time and health

1.6.1 Part-time work and health

1.6.1.1 The importance of part-time work

The review of the literature revealed that part-time might be a desired solution in cases where health problems restrict activity, in phased retirement, etc.

The SILC survey (2005) indicates that part-time work is important for women and people with chronic (longstanding) illness or condition. It reveals that part-time work is a preferred or imposed way to (re) enter the labour force of those who were previously inactive. This is true both for people with and without chronic illness or condition. The SILC survey (2005) reveals that part time work is more common in the service sector. One explanation might be that this is a labour intensive sector facing

fluctuations in demand. In this case, employers might find it easier to meet these fluctuations with part-time workers⁷⁴.

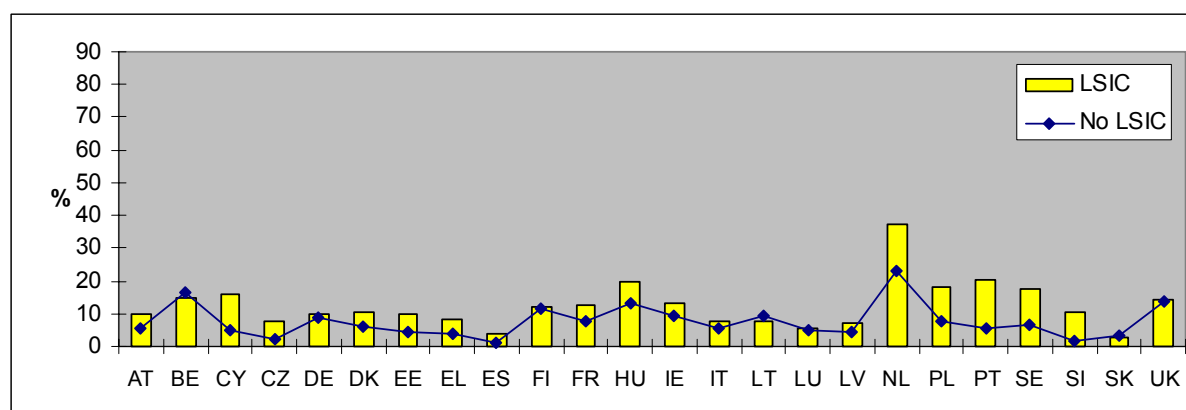
It is important to note that the SILC survey distinguishes as “Reason for working less than 30 hours (in main and other jobs)”: 1.Undergoing education or training, 2.Personal illness or disability, 3.Want to work more hours but cannot find a job(s) or work(s) of more hours; Do not want to work more hours; 5.Number of hours in all job(s) are considered as a full-time job; 6.Housework, looking after children or other persons; 7.Other reasons⁷⁵.

The LFS focuses on people who have a job or business and distinguishes: 1.Full-time job, 2.Part-time job (reason explained), 3.Part-time but no reason given, 4.Looking after children or adult. The two surveys produce slightly different results.

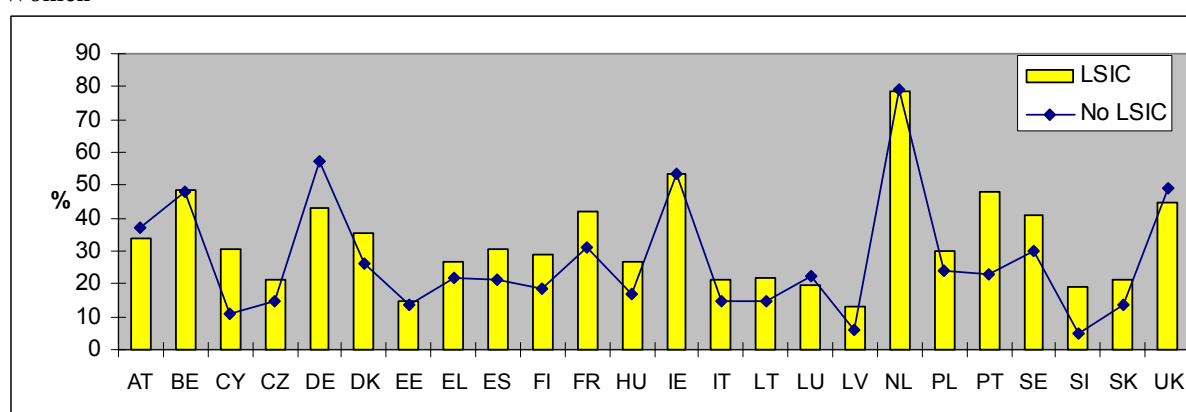
Part-time work enables older workers with health problems to remain in the labour market, but with less work pressure. This usually involves a reduction in income. Consequently, the demand for part-time work is likely to be greater in countries where the general level of salaries is high enough to allow for a decent standard of living among part timers.

There are big differences across Member States but this does not seem to be linked to labour force participation rates. Countries offering more part-time do not have higher labour participation.

Figure II.30: Part time work by sex and health status; age 55-64
Men



Women



Note: (LSIC: chronic (longstanding) illness or condition)

Source: SILC 2005

⁷⁴ Alicia Munnell: Policies to promote labor force participation of older people; Center for Retirement Research at Boston College; 2006

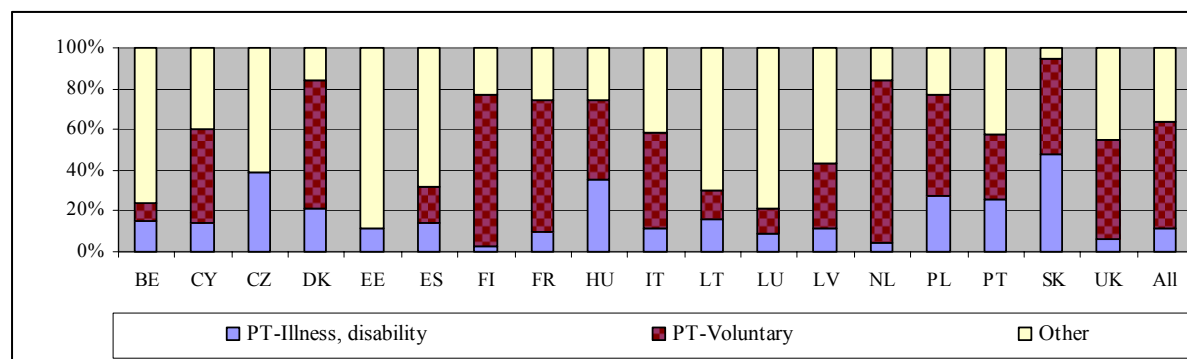
⁷⁵ It refers to the main reason for working less than 30 hours. In this way, only one response is ticked.

1.6.1.2 Reasons for working part-time

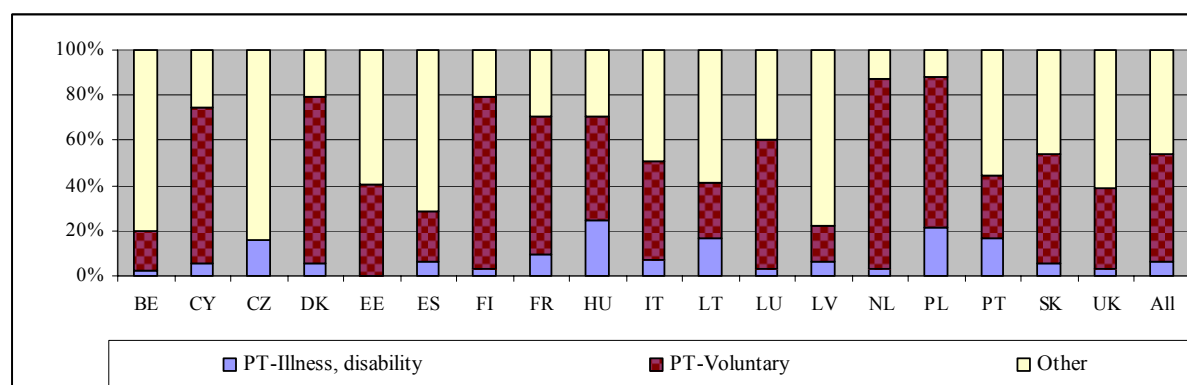
Part-time work due to illness or disability and voluntary (do not want to work more) increases with age. The share of illness decreases after the age of 55 probably due to early retirement due to invalidity. The SILC survey (2005) indicates that for the age group 60-64, about 55% of those working less than 30 hours advance “illness or disability” and “do not want to work more hours as the reason”.

It is important to note that the two surveys, LFS 2005 and SILC 2005, do not use the same classifications and the results are slightly different.

Figure II.31: Reason for working part-time by age group, age 55-64
Men



Women

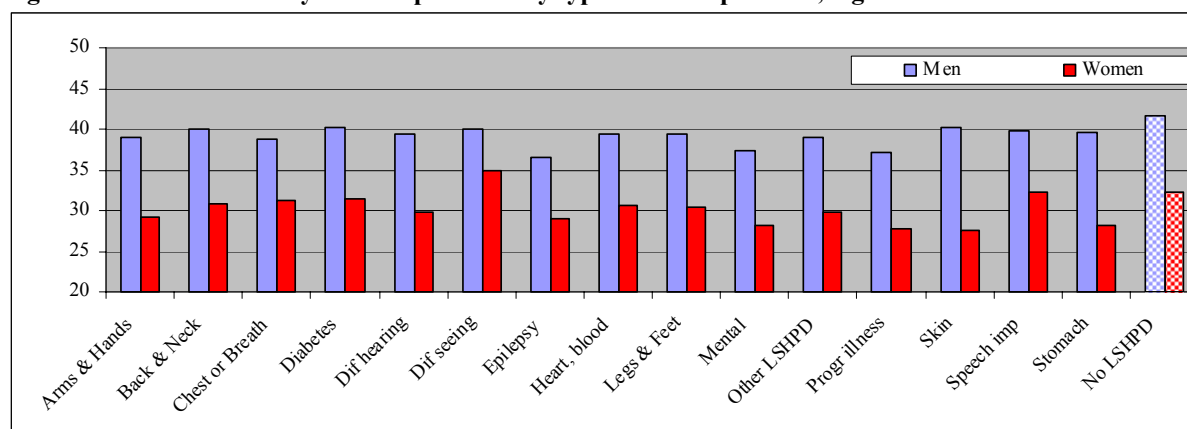


Source: LFS 2005

Voluntary part-time appears as an important factor, notably in countries with a high labour participation of older workers.

1.6.1.3 Nature of health problem

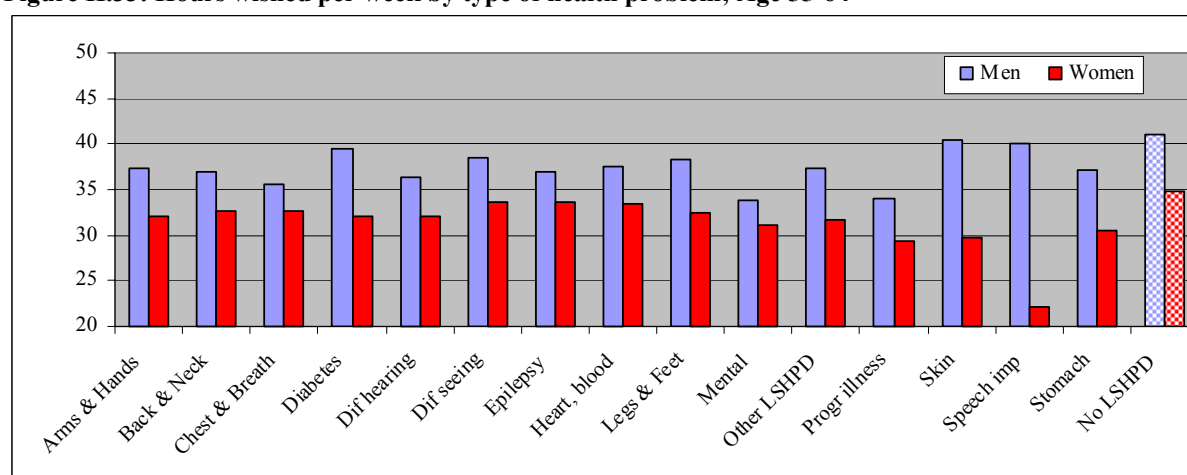
It is interesting to analyse the number of hours worked per week by type of health problems.

Figure II.32: Hours usually worked per week by type of health problem; Age 55-64

Notes: 01.Arms or Hands; 02.Legs or Feet; 03.Back or Neck; 04.Difficulty seeing; 05.Difficulty hearing; 06.Speech impediment; 07.Skin conditions; 08.Chest or Breathing prob.; 09.Heart, blood or circulation prob.; 10.Stomach, Liver or Digestive prob.; 11.Diabetes; 12.Epilepsy; 13.Mental, Nervous or Emotional prob.; 14.Other progressive illness; 15.Other LSHPD; 16. No LSHPD (Longstanding health problem and disability).

Source: LFS Ad hoc module 2002

The previous figure might not reflect desired patterns. Institutional rigidities might hide the desired solutions. Consequently, it is more interesting to analyse the number of hours wished per week.

Figure II.33: Hours wished per week by type of health problem; Age 55-64

Type of health problem: See notes of previous figure

Source: LFS Ad hoc module 2002

The two figures provide similar results. However, the amount of desired hours for men is less than the actual number. The opposite is true for women. The difference between men and women is reduced.

For men, mental health problems and other progressive illness are the more restrictive types. For women, speech, other progressive illness and skin appear to be the most disadvantaging.

It is interesting to note the big difference between men and women concerning speech problems. This might be due to the high concentration of women in the tertiary sector where oral communication might be an important factor. However, this requires further study.

1.6.2 Overtime work and health

As we said it in the first part, overtime work could damage health of the worker. But we do not find information about the life working time of retirees. So we analysed the feeling of older workers about their health and their ability to work until the regular retirement age. SHARE data show that many Europeans report being afraid that their health limits their ability to work before regular retirement. We can note that men and women do not answer in the same way. Men overtime workers feel more confident in their health than women overtime workers. This might be due to the difference in jobs and sectors of occupations.

We selected overtime workers (50-64 years) and looked at their general health status. The results indicate that the better is the health the more important is the incidence of overtime work. There are still differences between men and women. This might reflect a self-selection process. Healthy workers may choose overtime contrary to people with health problems.

To conclude, we can say that the long term impact of overtime on health has to be taken into account. Even if those who are doing overtime feel well now, they could go through health problems latter in their life.

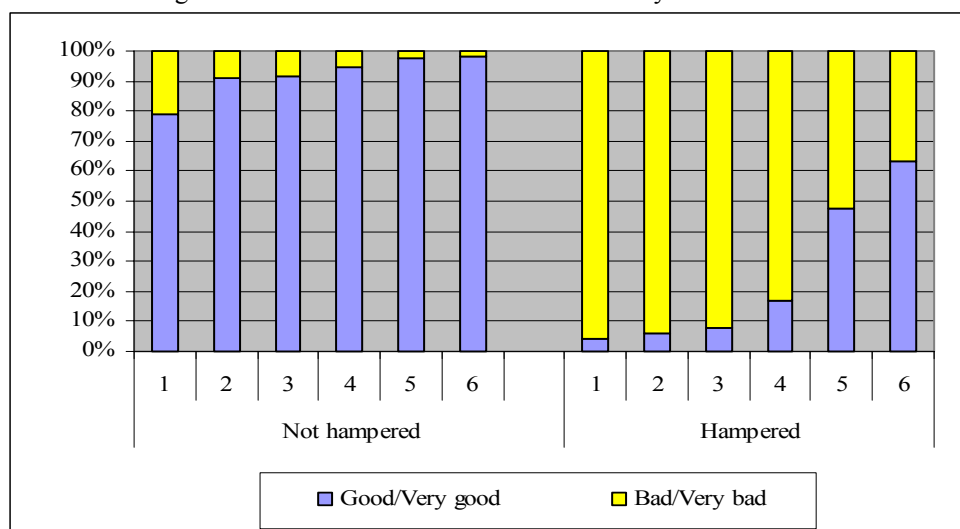
1.7 Job satisfaction, health and retirement

Job satisfaction may affect retirement directly or through health.

Different surveys report that people satisfied with their jobs declare a better health. However, the causality might run from work satisfaction to health and from health to work. In order to give a better picture of the situation, we distinguish below people hampered in their daily activities and people not hampered.

Even if we restrict our analysis to people not hampered, we may observe that the percentage of people declaring bad or very bad health increases as job satisfaction decreases (in the scale, we go from 6 to 1).

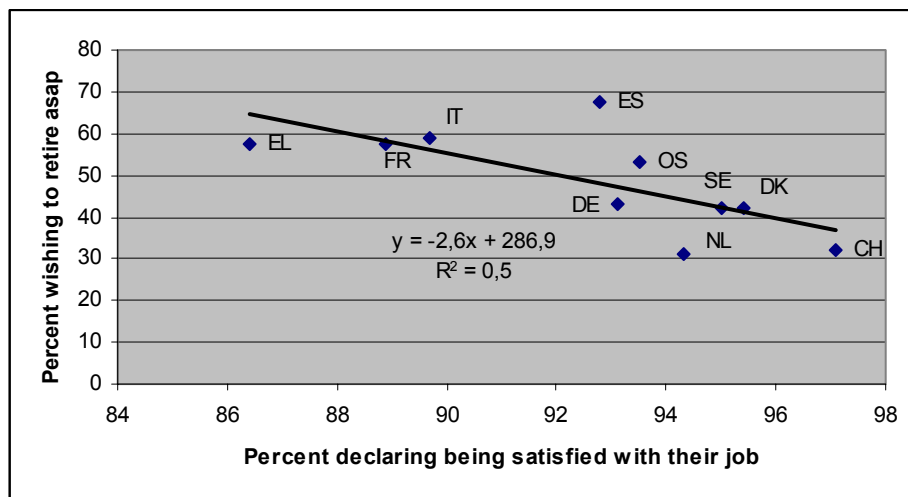
Figure II.36a: Health by degree of satisfaction with work or main activity of people aged 55-64
Degree of satisfaction: 1: not satisfied ... 6: fully satisfied



Source: ECHP UDB 2001

As noted in Part I, job satisfaction seems to exert a strong impact on retirement decisions. People with a low job satisfaction desire to retire as soon as possible.

Figure II.36b: Percent of people aged 50-64 wishing to retire as soon as possible and persons declaring being satisfied with their jobs



Source: SHARE 2004

The previous figure indicates a significant negative relation between job satisfaction and desire to retire as soon as possible.

1.8 Conclusions

The statistical analysis has confirmed the results of the review of the literature:

- health status is one of the most important determinants of labour supply among older workers
-
- deterioration in health status results in early departure from the labour market
-
- most individuals in bad health will stop working at an early stage
-
- individuals in good health will retire later.

Concerning prevalence of chronic illness, lower education level, lower occupational level (current or previous) and lower relative income increases the probability to report a longstanding health problem or condition.

Health is an important factor affecting labour force participation:

- There is an important gender difference relating to health and labour force participation. Men with longstanding health problems or disabilities seem to require specific policies. General conditions seem to be more important for women than for men.
- A higher education and occupational skill increase the probability to participate on the labour market.

- The marital status is not significant for people with longstanding illness or condition.

The statistical analysis concerning exits and entries from the labour force reveals that:

- People who exit the labour force report a higher prevalence of chronic (longstanding) illness or condition compared to those who stay in the labour force.
- Exits increase with age
- Separated people have a relatively high rate of (re) entries compared to exits into the labour market (both for people with and without chronic illness or condition).
- People with mental health problems and “other progressive illness” constitute the most vulnerable groups. The exit rate of this group is relatively high and the (re) entry rate is low.
- Health and education are the most important factors affecting exits and entries in the labour force.
- Those who exit the labour force have a long history of unemployment.

Part-time work is important for women and people with chronic (longstanding) illness or condition:

- Part-time work is a preferred or imposed way to (re) enter the labour force of those who were previously inactive. This is true both for people with and without chronic illness or condition.
- Part-time work due to illness or disability and voluntary part-time work (do not want to work more) increases with age.
- For the age group 60-64, about 55% of those working less than 30 hours advance “illness or disability” and “do not want to work more hours as the reason”.
- For men, mental health problems and other progressive illness are the more restrictive types. For women, speech, other progressive illness and skin appear to be the most disadvantaging.
- Part-time work might involve a reduction in income. The demand for part-time work is likely to be greater in countries where the general level of salaries is high enough to allow for a decent standard of living among part timers.

Job satisfaction is a significant factor affecting the timing of retirement.

II.2. Financial (dis) incentives

2.1 Introduction

In Part I it was noted that people with health problems and chronic illnesses might be more prone to absenteeism than the rest of the population. Workers with chronic illness are more likely to fail to turn up to work than workers without a chronic condition. However, this conclusion was not unanimous.

Also, the previous chapter revealed the importance of chronic illness as an important factor determining labour participation and exit from the labour market. The exit road might imply a long period of absenteeism from work or the disability exit road.

Consequently, we study below absenteeism and disability aspects of older workers.

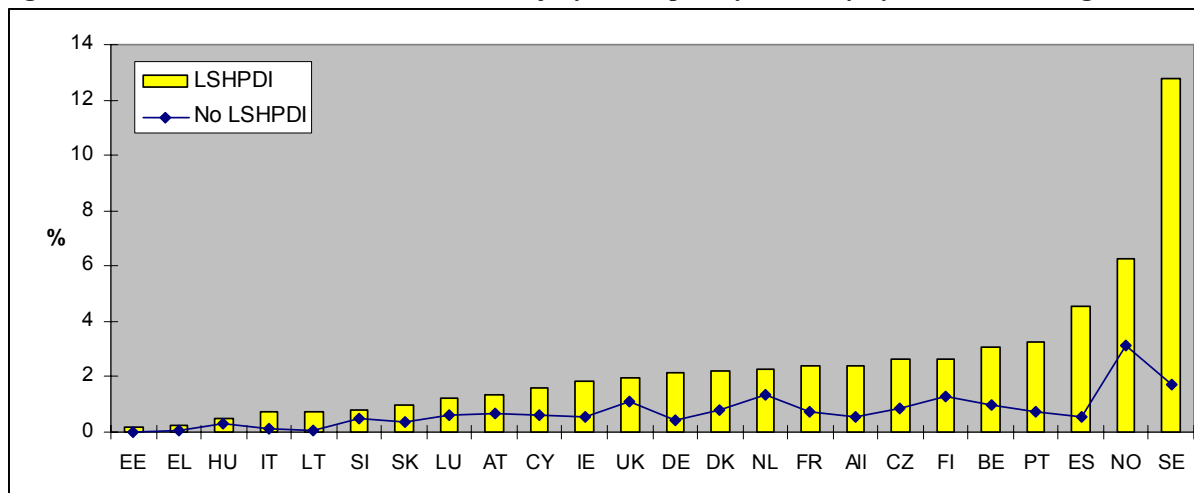
2.2 Absenteeism, health and disability

Absenteeism is important because it might be an important cost for the employer who hires older workers. It is thus interesting to study further this issue. The LFS Ad hoc module 2002 presents the reason for not having worked at all though having a job (Was not working but had a job or business from which he/she was absent during the reference week).

The importance of absenteeism may be measured in terms of the labour force of people aged 55-64 years. Absenteeism due to own illness, injury or temporary disability represents 1,3% of people without a longstanding health problem or disability and 8,1% for people with a longstanding health problem or disability. There are no significant gender differences for people with a longstanding health problem or disability. It may also be measured in terms of all people of the same age group. Absenteeism represents 0,6 % of people without a longstanding health problem or disability and 2,4% for people with a longstanding health problem or disability

Certain countries experience a high labour force participation of people with chronic illness or disability. This could explain partly a high rate of absenteeism in these countries (e.g. Sweden). In order to compare the impact of absenteeism with labour force participation, we report percentages in terms of all persons of the same age group.

It is important to note that the rate of absenteeism depends on the general economic situation. This means that comparisons across countries ought to take into account the different economic situations.

Figure II.37: Absenteeism due to own illness, injury or temporary disability by health status; Age: 55-64;

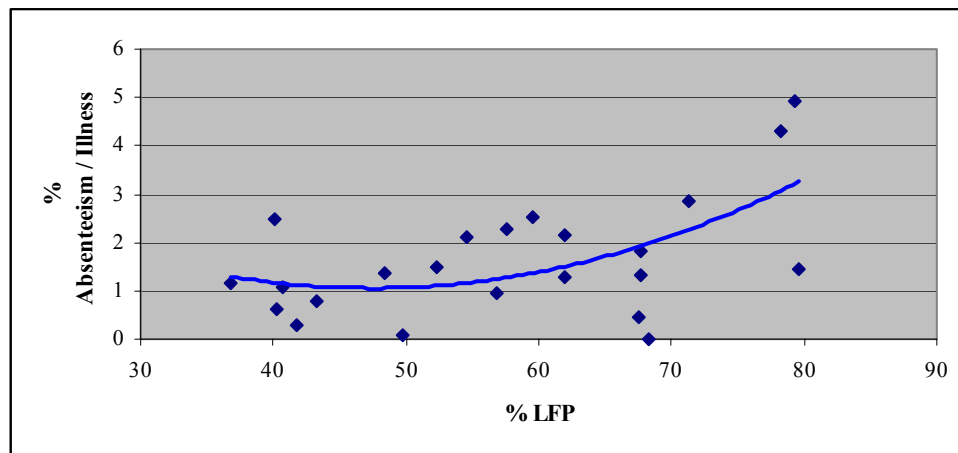
Note: LSHPDI: Longstanding health problem or disability

How to read: In Sweden, 13% of all persons aged 55-64 with a LSHPDI were absent (though having a job) during the reference week due to own illness, injury or temporary disability.

Source: LFS Ad hoc module 2002

The previous figure indicates, as expected, that people with a longstanding health problem or disability report a higher rate of absenteeism due to own illness, injury or temporary disability.

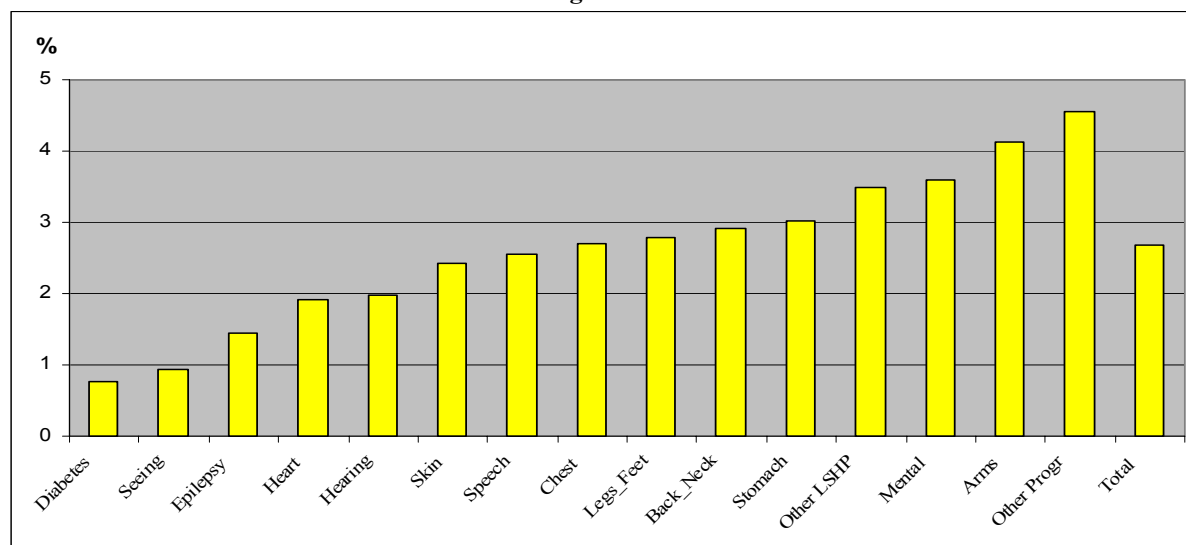
In the following figure, we present the labour force participation and the rate of absenteeism by country. We may observe a (weak) relation between labour market participation and absenteeism for people aged 55 to 59. We excluded the age group 60-64 in order to reduce the institutional impact (early retirement schemes, legal retirement age, etc.).

Figure II.38: Labour Force Participation (LFP) and Absenteeism due to own illness, injury or temporary disability; Age: 55-59

Source: LFS Ad hoc module 2002

As noted in the literature the deteriorating nature of illness is an important factor determining labour participation. Persons with “Other progressive illness or disability” experience the highest absenteeism due to illness.

Figure II.39: Absenteeism due to own illness, injury or temporary disability by type of health problem; Age 55-64



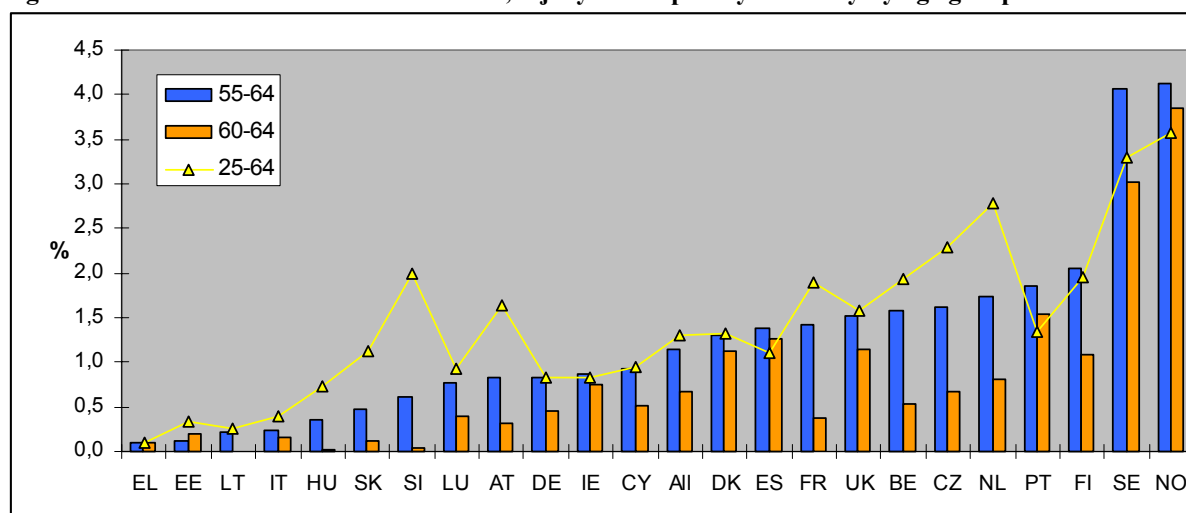
How to read: Among all persons aged 55-64 who declare a progressive illness, 4,5% were absent (though having a job) during the reference week due to own illness, injury or temporary disability

The LFS distinguishes: 01.Arms or Hands; 02.Legs or Feet; 03.Back or Neck; 04.Difficulty seeing; 05.Difficulty hearing; 06.Speech impediment; 07.Skin conditions; 08.Chest or Breathing prob.; 09.Heart, blood or circulation prob.; 10.Stomach, Liver or Digestive prob.; 11.Diabetes; 12.Epilepsy; 13.Mental, Nervous or Emotional prob.; 14.Other progressive illness; 15.Other LSHPD; 16. No LSHPD (Longstanding health problem and disability).

Source: LFS Ad hoc module 2002

The following figure indicates that older workers are not those with the higher absenteeism rate. However, one has to remember that the average duration of sickness of older workers is longer compared to younger workers (see Part I).

Figure II.40: Absenteeism due to own illness, injury or temporary disability by age group



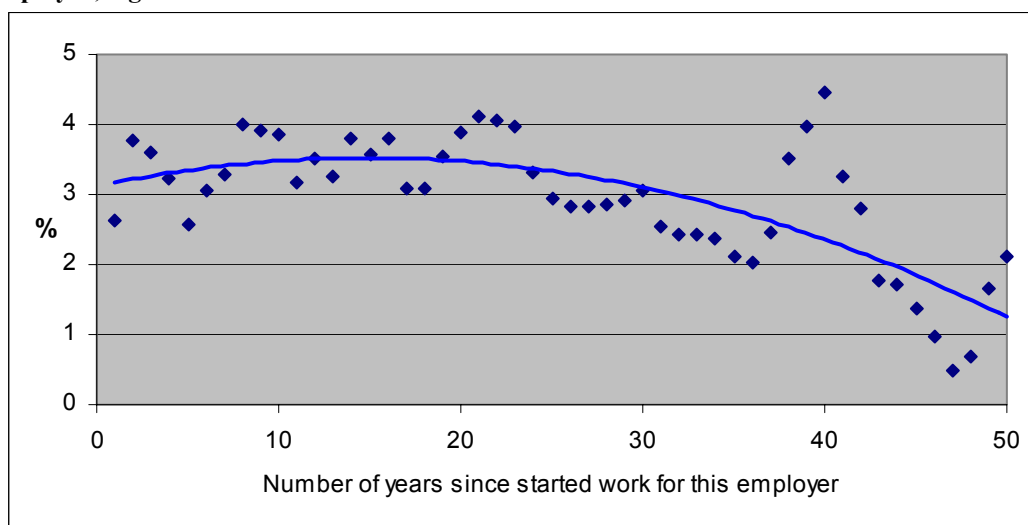
How to read: In Sweden, 4,1% of all persons aged 55-64 were absent (though having a job) during the reference week due to own illness, injury or temporary disability.

Source: LFS Ad hoc module 2002

The figure is compatible with existing studies (see Part I) reporting a high rate for Sweden, Finland and the Netherlands.

But there is a self selection. People with a long history in the same company report less absenteeism because workers not satisfied have already gone.

Figure II.41: Absenteeism due to own illness, injury or temporary disability and number of years with the same employer; Age 55-64



Source: LFS Ad hoc module 2002

How to read: From people aged 55-64 with 10 years in the same employer 3,5% were absent (though having a job) during the reference week due to own illness, injury or temporary disability.

Note: The percentages have been smoothed by a 3 years moving average.

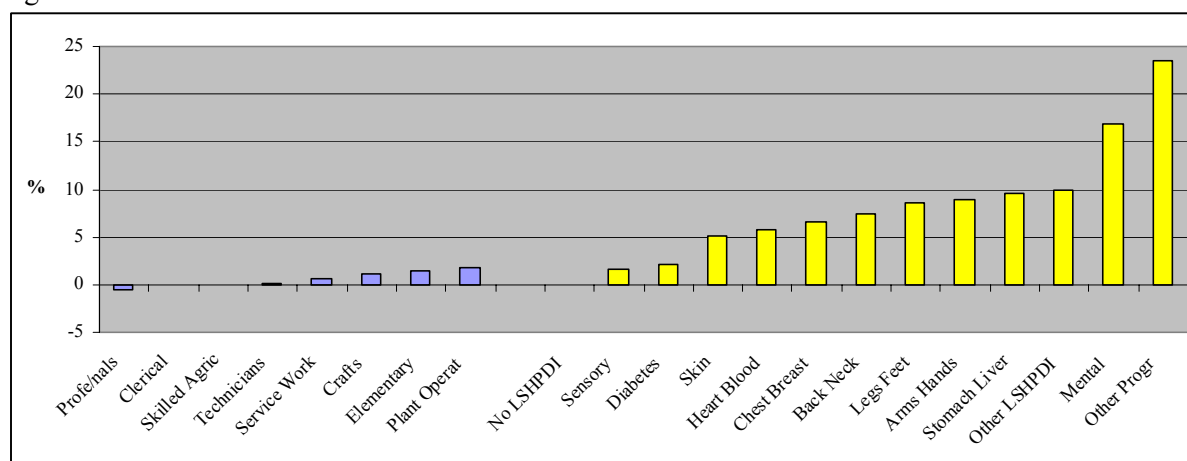
Econometric analysis

We run probit estimations where the alternatives were working and absent due to illness, injury or disability although having a job. We used country dummies, sex, age, education, occupation, sector and type of illness as arguments.

The results for the age group 25-64 indicate that age and being woman increases significantly the probability of absenteeism (unlike the previous graphs) but the impact is extremely low. Education and marital status deliver the expected results. Higher education⁷⁶ as well as widowed, divorced or separated increases the probability to be absent. Similarly, higher skills decrease the probability of absenteeism. Working in the public, education or health sector increases the probability of absenteeism. All the above factors modify the expected probability by less than 1%. The type of illness has a much stronger impact.

⁷⁶ Higher level of education but keeping age, skills, etc constant.

Table II.42: Probability change to be absent due to own illness, injury or temporary disability; Age 55-64.



Note: Sample probability 3%. The estimation sample is not the same as for previous figures due to lack of information concerning the arguments used in the estimation.

Base variables: “Clerical” and “No longstanding health problem or disability” (No LSHPDI) are used as base for comparison. Type of longstanding health problem: 01.Arms or Hands; 02.Legs or Feet; 03.Back or Neck; 04.Difficulty seeing; 05.Difficulty hearing; 06.Speech impediment; 07.Skin conditions; 08.Chest or Breathing prob.; 09.Heart, blood or circulation prob.; 10.Stomach, Liver or Digestive prob.; 11.Diabetes; 12+13:Epilepsy, Mental, Nervous or Emotional prob.; 14.Other progressive illness; 15.Other LSHPD; 16. No LSHPD (Longstanding health problem and disability).

The results for the age group 55-64 are similar in their direction (although age and sex are not significant) but the impact of occupation and type of illness is much stronger.

“Other progressive” appears to be the strongest factor affecting absenteeism as indicated above.

For comparison, Leontaridi and Ward (2002) analyse 15 OECD countries from the International Social Survey Program. They find that those individuals reporting to experience at least some stress in their current position are 10 - 14 % more likely to hold intentions to quit or be absent from work than those without any job stress, with the probability of intending to quit or being absent increasing with successively higher work related stress levels⁷⁷.

In the previous analysis, we did not take into account explicitly institutional factors. Their impact ought to be included in the value of dummy variables used for countries.

As noted in Part I, certain authors argue that the generosity of granting sick leave is an important factor explaining differences of sick leave days per employee across countries.

We have tested the measure of generosity proposed by Osterkamp and Röhn (2007) with our data. Our findings do not confirm the relation between this measure of generosity of sick leave and our measure of absenteeism. However, our data support their conclusion that the employment of older persons is important, but as a proxy for health problems. A major characteristic of our measure of absenteeism is the inclusion of short term spells while administrative data generally do not cover them. In fact, administrative data often do not include very short absenteeism paid by the employer and not covered by sickness insurance.

In the following, we analyse further sickness and disability reciprocity.

⁷⁷ Work-Related Stress, Quitting Intentions and Absenteeism: Rannia M. Leontaridi and Melanie E. Ward; IZA Bonn and CEPR Discussion Paper No. 493, May 2002

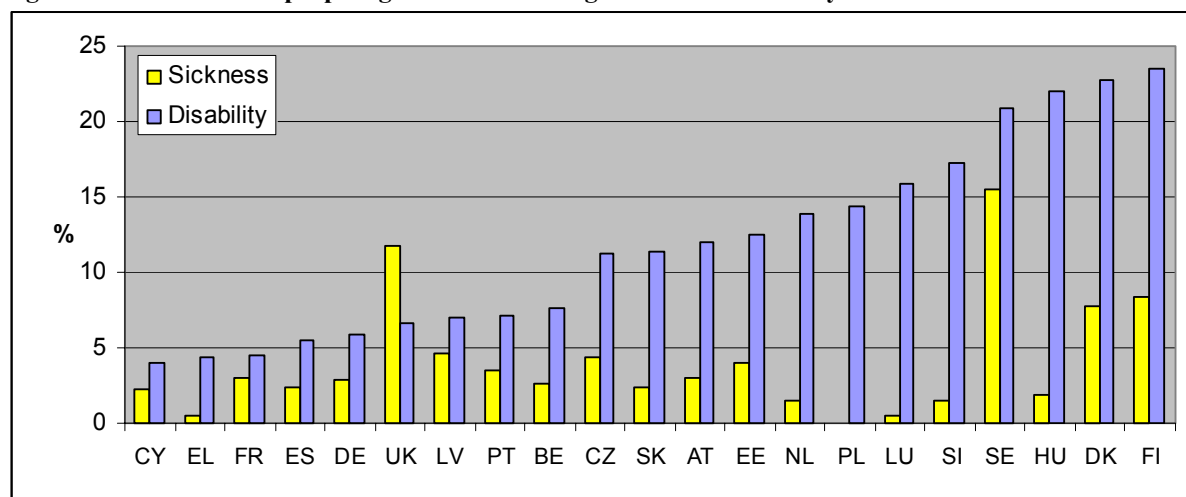
2.3 Persons receiving sickness and disability benefits

Some people have argued that high replacement rates and laze conditions of eligibility have played a role in making disability the main means for achieving early exit from the labour market in the Netherlands and Sweden. Other countries such as France or Germany have favoured premature exits from the labour market by unemployment systems (for example job seeking exemptions in France).

Social protection of people with chronic illness or disability rests mainly on sickness and disability benefits. The following figure presents the number of persons aged 55 to 64 receiving such benefits. We may notice a big difference across Member States. The relative variability (standard error) for disability benefits is higher compared to sickness benefits.

The reception of a sickness benefit does not imply necessarily a long term illness or condition. For this reason, we will focus on disability benefits. The definition of disability benefits used by SILC is relatively large (invalidity pensions, disability social assistance, etc.).

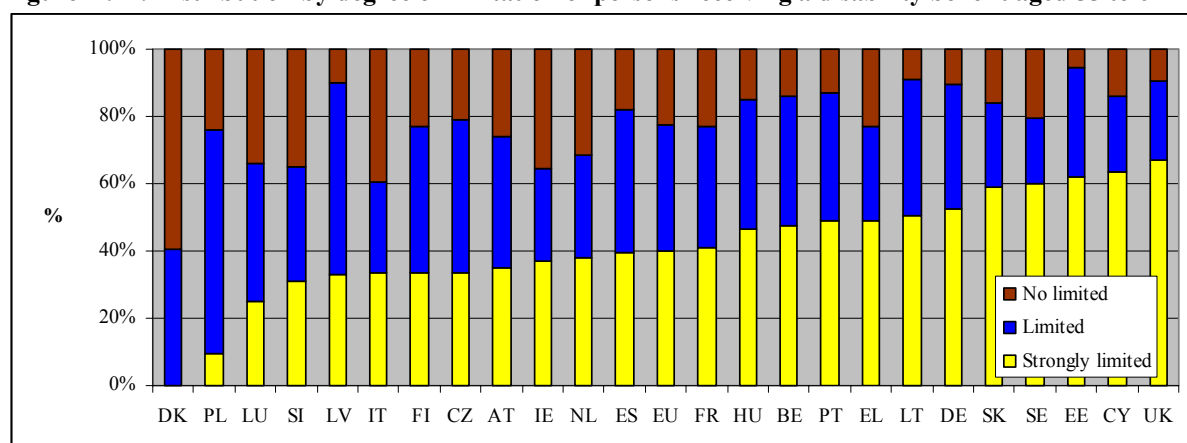
Figure II.43: Number of people aged 55-64 receiving sickness or disability benefits



Note: ordered by disability benefits
Source: SILC 2005

The question is whether the granting of a disability benefit acts as a disincentive to labour market participation. In the following, we will use data from the SILC survey, notably the concept of activity limitations with the distinction strongly limited, limited and no limited.

The next figure indicates that of those receiving a disability benefit, aged 55 to 64, about 77% declare a limitation while 23% declare being not limited. There are big differences across Member States. It is important to note that occupational accidents and diseases in the Member States may give right to an annuity for relatively low invalidity rates. This might explain partly, why some people receiving a disability benefit declare no activity limitation.

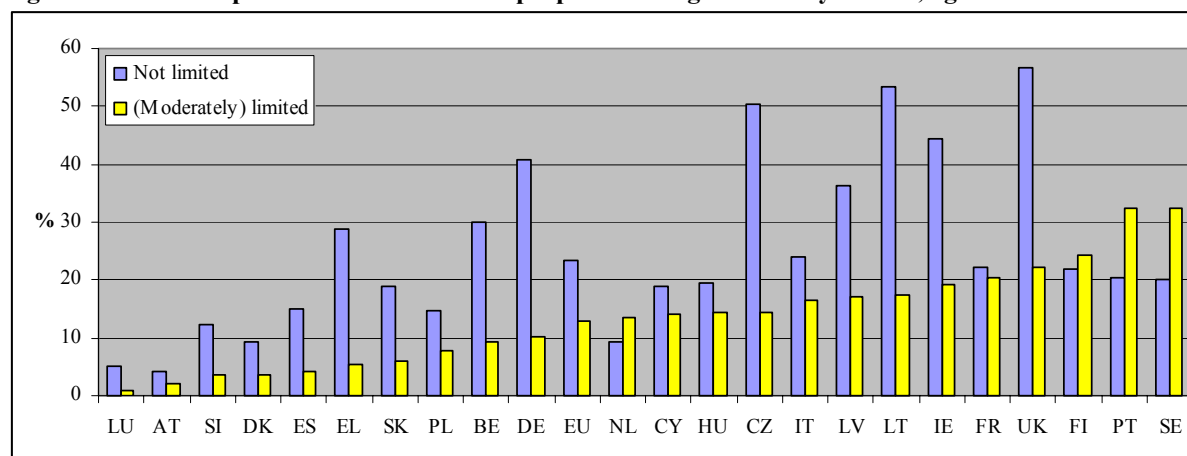
Figure II.44: Distribution by degree of limitation of persons receiving a disability benefit aged 55 to 64

Note: DK does not distinguish “strongly limited” and “limited”. In DK invalidity benefit is granted to people with disabilities and people with social conditions.

Source: SILC 2005

The public debate focuses on disability benefits and employment. We prefer the concept of labour force participation instead of employment. In fact, the lack of employment may result either from a lack of job offers or from high reservation rates due to disability benefits.

The next figure indicates that people receiving a disability benefit with a moderate limitation have a high participation rate in some countries (e.g. Sweden, Portugal, Finland) and very low in other countries (e.g. Luxembourg, Austria, Slovenia).

Figure II.45: Participation in labour force of people receiving a disability benefit, aged 55-64

Note: We distinguish two categories: declaring “(moderately) limited” and “not limited”

Ordered by (Moderately) limited

Source: SILC 2005

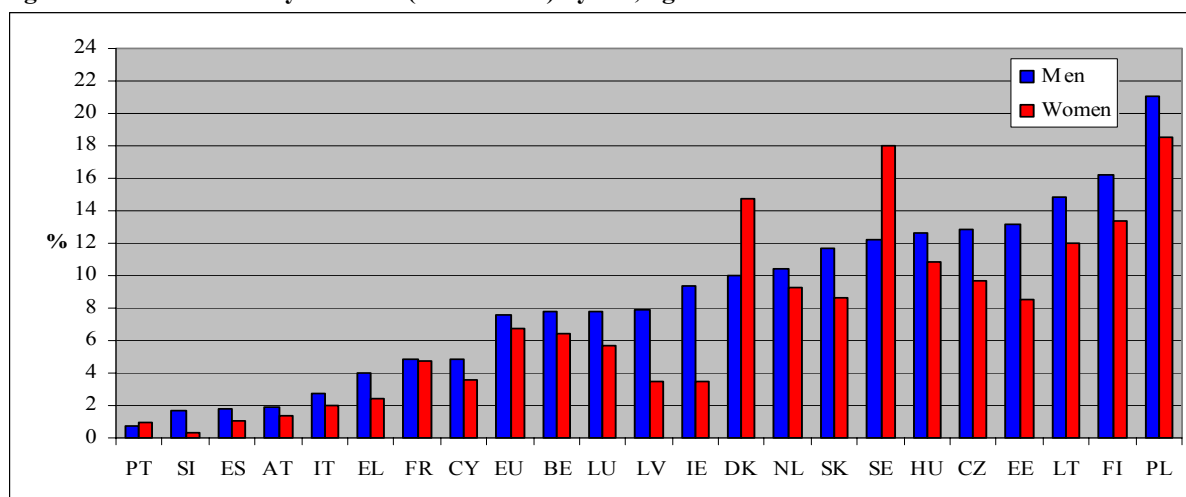
The participation rate of recipients with a moderate activity limitation varies between 1% (Luxembourg) and more than 30% in Sweden. Consequently, there is a potential to increase labour participation in a certain number of Member States. Relevant policies may induce invalidity pensioners with a moderate limitation to remain on the labour market.

2.4 Persons permanently disabled

In the previous chapter we focussed on moderately disabled people. Here we will study “permanently disabled”. This could be grossly compared to inactive people receiving disability benefits declaring being strongly limited.

In fact, the Labour Force Survey defines the main status as: 1) carries out a job, 2) unemployed, 3) pupil/student, 4) in retirement or early retirement, 5) permanently disabled, 6) military service, 7) fulfilling domestic tasks, and 8) other inactive. There are big differences across Member States.

Figure II.46: Permanently disabled (main status) by sex; age 50-64*



*: We present data for people aged 50-64, in order to increase the liability of reported percentages by country and sex.

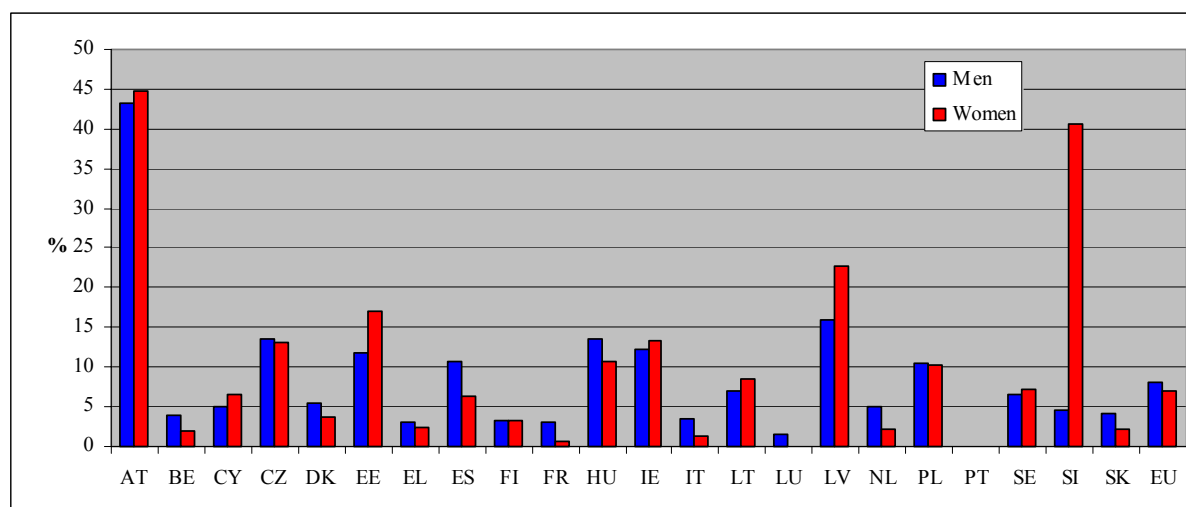
Note: In Poland disability might contain people with illness.

Source: LFS 2005

If we take only those permanently disabled not in employment currently, about 43% of permanently disabled aged 50-64 have ever worked in the past; this group might contain a high proportion of people with congenital severe disabilities. Among those who have ever worked, men have a relatively more recent experience compared to women.

A very small proportion of people permanently disabled desires to have a job. Interestingly, they would like to work for 25 hours (men: 27 hrs, women: 22 hrs) compared to 38 hours for all people.

Figure II.47: Permanently disabled aged 50-64 (not seeking employment) but would like to have a job, by sex



Source: LFS 2005

Furthermore, the education level of permanently disabled is comparatively low and this makes their employability weak. The above characteristics indicate that this group has a little potential in terms of labour force participation, in the majority of Member States.

2.5 Conclusions

Concerning people aged 55-64 participating on the labour market, absenteeism due to own illness, injury or temporary disability represents 1,3% of people without a longstanding health problem and 8,1% for people with a longstanding health problem. The data reveal that:

- There are no significant gender differences
- There are differences across countries
- Illness has a much stronger impact on absenteeism than education, age and marital status
- Persons with “Other progressive illness or disability” experience the highest absenteeism

The participation rate of people receiving a disability benefit with a moderate activity limitation varies between 1% (Luxembourg) and more than 30% (in Sweden). This means that there is a potential to increase labour participation in a certain number of Member States. Relevant policies may induce invalidity pensioners with a moderate limitation to remain on the labour market.

If we take only those permanently disabled not currently in employment:

- About 43% of permanently disabled aged 50-64 have ever worked in the past
- A very small proportion of people permanently disabled desires to have a job
- They would like to work for 25 hours compared to 38 hours for all people
- The education level of permanently disabled is comparatively low.

The above characteristics indicate that this group has a little potential in terms of labour force participation and employability in the majority of Member States.

II.3. Active ageing

3.1 Introduction

The ageing of the population and the increasing health care costs have pushed several member States to introduce programmes aiming to promote active ageing among elderly people. As it was noted in the previous parts of this report, activity and health are closely correlated.

In order to understand better the situation in the Member States, we look at some indicators of active ageing in the next section.

We begin with a statistical analysis of participation in a certain number of activities which were identified as important determinants of healthy ageing in the previous chapters. Consequently, we focus on sport, social activity in clubs, participation in training courses and physical activity of the elderly.

SHARE asks people if they do: 1) volunteering, 2) a sport and social activity in club, 3) educational and training courses, 4) physical activity, etc. A person may fill several items simultaneously.

We will analyse voluntary work separately as it raises a certain number of specific issues.

3.2 Activity and health

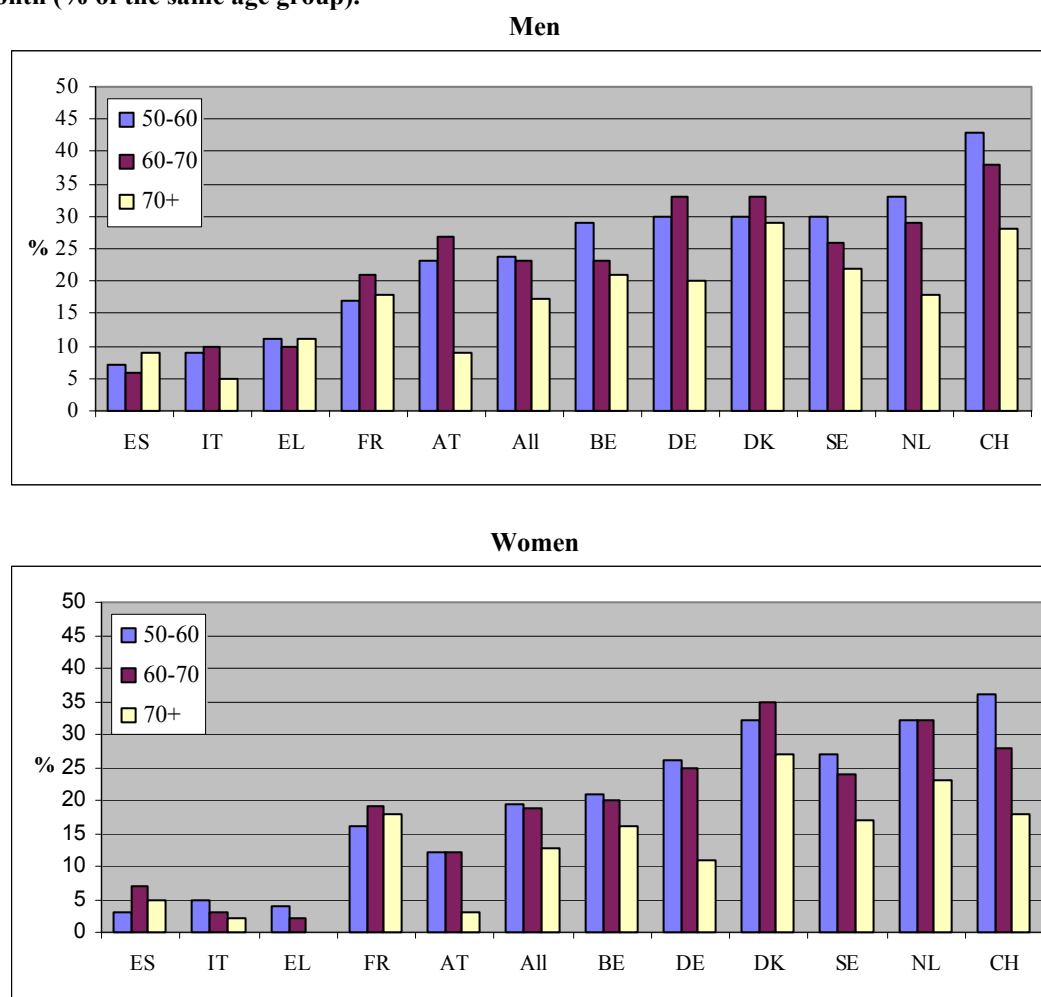
3.2.1. *Sport and social activity in club*

The next table shows the number of people participating in clubs in Europe. We may note that this participation is lower in southern European countries (Greece, Spain and Italy).

Concerning gender, the percentage is generally lower for women compared to men.

The participation in such activities seems to decrease with age.

Table II.48: Number of persons who participate in a sport, social or other kind of club at least one time in the month (% of the same age group).



Source: Share wave 1 release 2, weighted results

Another important information is the frequency of such participation in one month. We find that these activities are mainly weekly activities. The frequency does not seem to change with age.

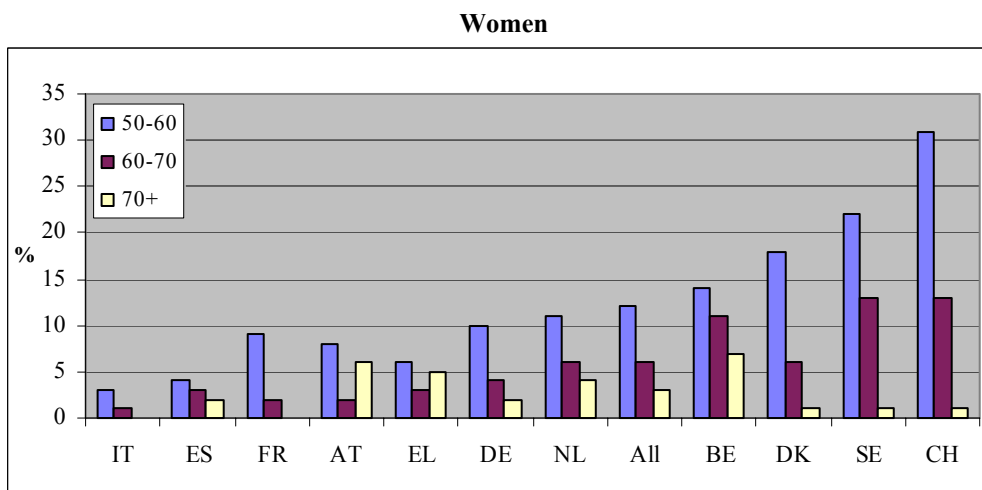
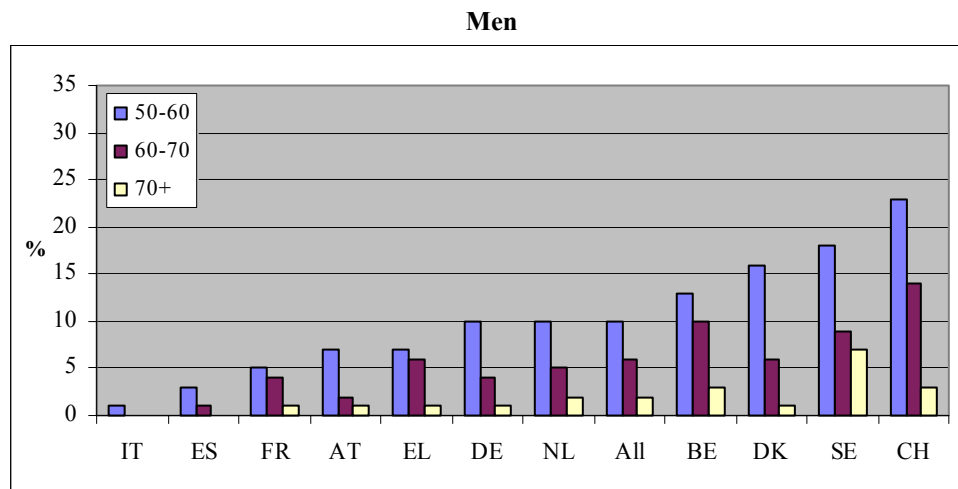
3.2.2 Educational and training course

Participation in education and training is important for cognitive performance and a healthy ageing. As mental problems are increasing for all ages, it is important to report the number of people participating in educational or training courses.

This participation is lower for Mediterranean countries. This might result partly from lower opportunities offered by employers in these countries. Nordic countries (notably Denmark and Sweden) offer relatively more often occupational training. The high level of participation in such activities in Denmark and Sweden decreases sharply for the age group 60 to 70 years as occupational training opportunities decrease.

Concerning gender, it is often higher for women than for men. We can also notice that the participation in such activities decreases with age.

Table II.49: Number of persons who attended educational or training course at least one time in the month (% same age group)

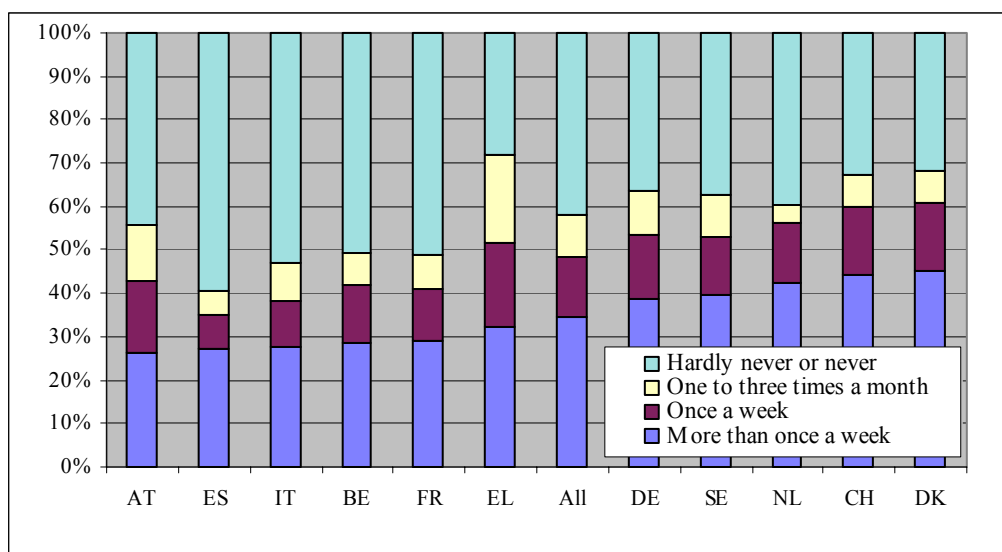


Source: Share wave 1 release 2, weighted results

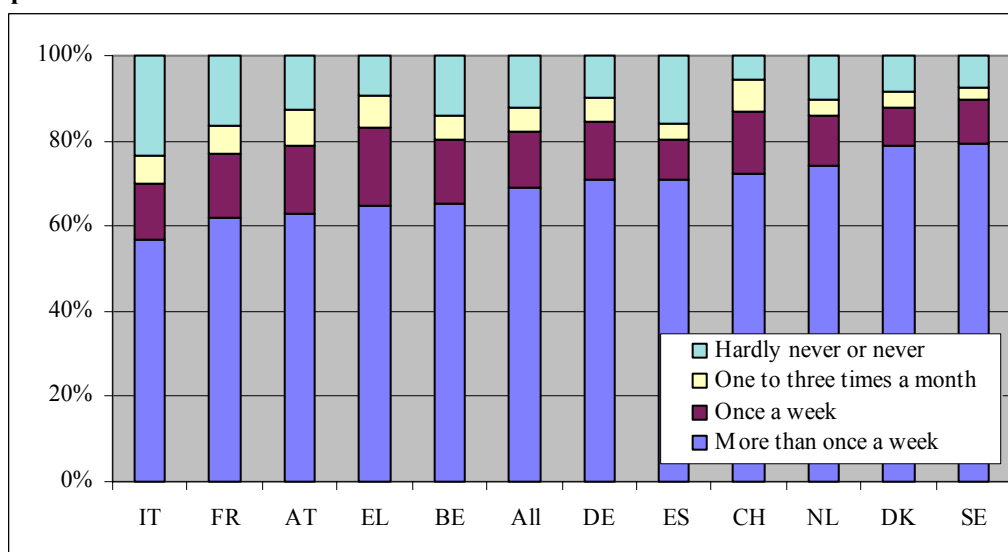
If we look at the frequency of such participation in one month, we find that the frequency of this participation seems to vary with age. The oldest declare going more at daily and weekly course. The “youngest” declare going more at a monthly course.

3.2.3 Physical activity

The next tables show the number of people participating in vigorous and moderate activities by country and by sex. We can notice that vigorous activity is less frequent than activities requiring a moderate level of energy among the elderly. We can see that women do less often vigorous activities than men. For moderate activities it's more or less the same incidence for men and women.

Table II.50: Number of people participating in sports or activities that are vigorous by country; Age group 50+

Source: Share wave 1 release 2, weighted results

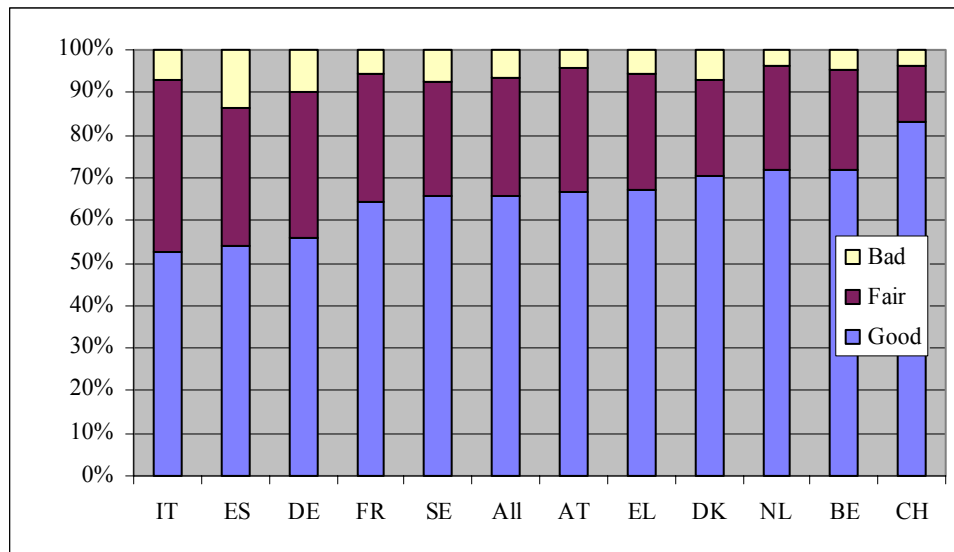
Table II.51: Number of people participating in activities requiring a moderate level of energy by country; age group 50+

Source: Share wave 1 release 2, weighted results

3.2.4 Activity and health

We look at the health status of Europeans who did at least one of the activities presented above during the last month. Results are presented in the following table. To achieve this, we used the self-reported health status in SHARE.

Figure II.52: Self-reported health status of Europeans who did activity during the last month ; age group 50+

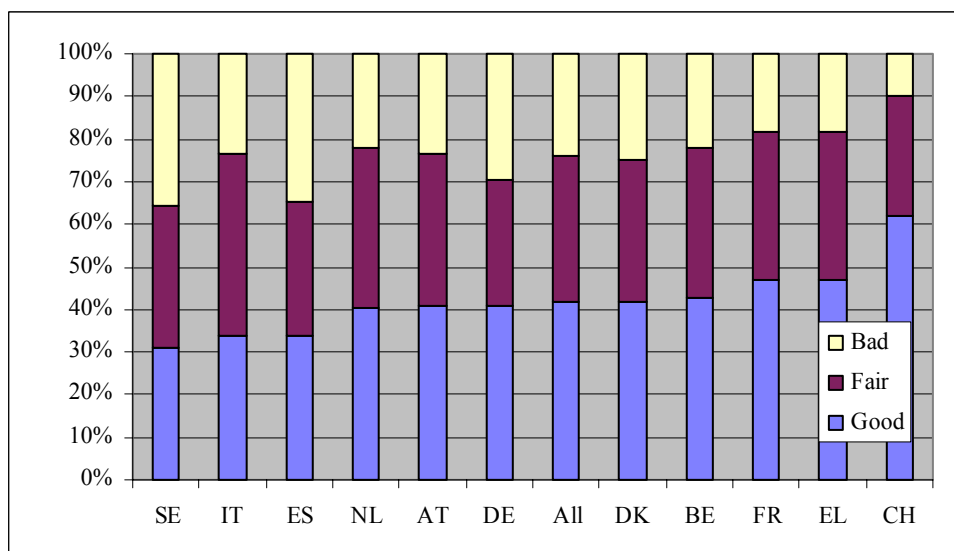


Source: Share wave 1 release 2, weighted results

We can notice that most of “active” Europeans have a good health. The health status of active Europeans differs depending on the country.

We can compare these results with the health status of Europeans who did not do activity. The next table shows that “inactive” Europeans are less good health compared to active Europeans. This is because Europeans in better health participate more to different activities.

Figure II.53: Self-reported health status of Europeans who did not do activity during the last month; age group 50+



Source: Share wave 1 release 2, weighted results

3.3 Volunteer work and health

3.3.1 Volunteer work by country

Judged by the per cent of civil society workforce of all economically active persons, the size of civil society sector varies from country to country. On average, approximately 7% of economically active persons work for civil society sector.

The level of volunteering varies between countries. However, such figures are highly vulnerable to methodological issues such as definition and data sources.

In some countries lower volunteering may be related to a high prevalence of informal volunteering that might be the case for Germany and Austria. In certain countries, elderly is mainly helped by members of the family. This kind of informal care decreases both the need for formal volunteering and opportunities to volunteer for the family members.

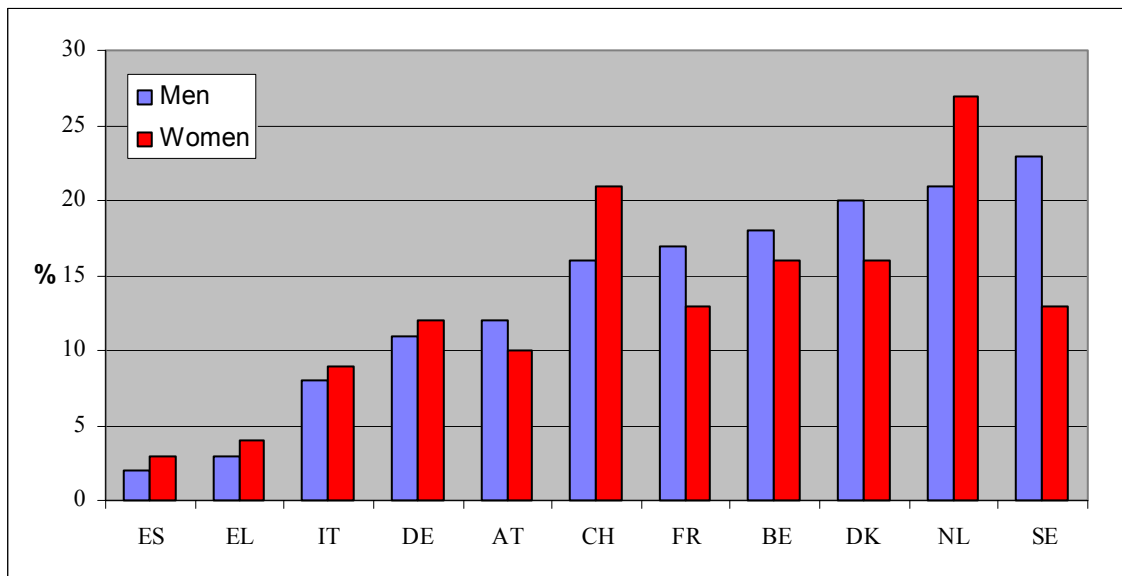
Table II.54: Percent of Europeans who has done volunteer or charity work by country sex and occupation (Age group 50-64)

	Retired		Employed		Unemployed		Disabled		At home	
	Men	Wom	Men	Wom	Men	Wom	Men	Wom	Men	Wom
BE	22	21	16	15	21	15	14	6	29	19
CH	18	14	16	19	0	25	20	21	33	27
DK	17	19	20	15	24	26	36	9	0	8
DE	15	10	10	10	11	15	2	0	0	20
EL	3	6	4	5	0	0	0	50	0	2
ES	2	9	2	3	3	0	0	0	-	4
FR	21	19	16	12	17	16	16	11	0	12
IT	11	18	7	6	0	14	0	0	-	6
NL	23	30	20	23	29	22	16	28	29	32
AT	11	11	15	10	4	14	14	0	0	7
SE	17	13	25	14	24	7	15	10	-	30
All	15	15	14	13	15	14	13	13	17	13

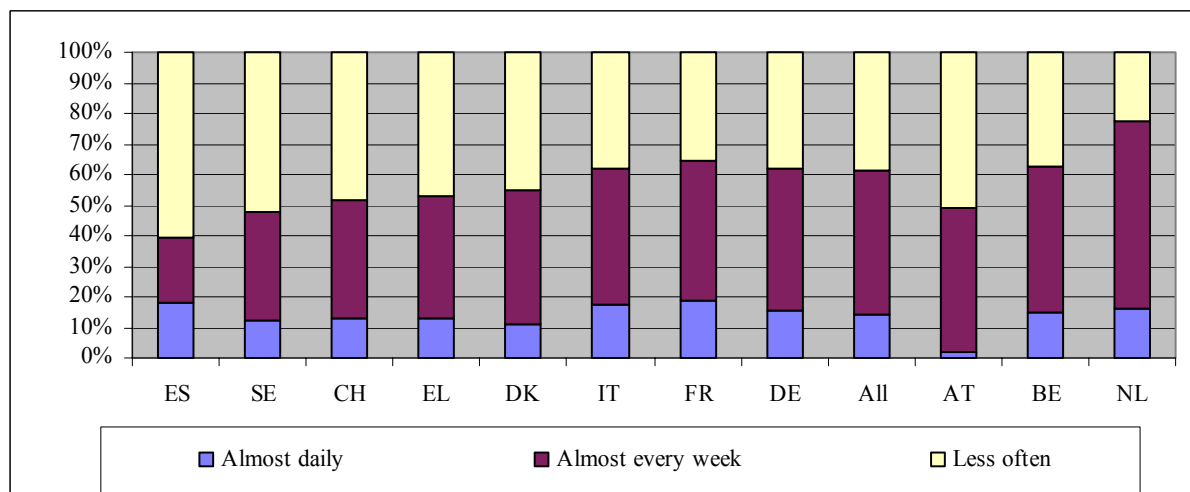
Source: SHARE, wave 1, release 2

There are only minor differences in activity between females and males.

Among volunteers, females and males contribute as many hours. Among older people males can use more of their time in volunteering than women, probably due to the traditional distribution of tasks inside the household which is more demanding for women (Wilson 2000). Females and males can, however, be interested in different types of volunteering.

Figure II.55: Participation in volunteer work by country (%) Age group 50-64

Source: SHARE wave 1, release 2

Figure II.56: Frequency of volunteer work (%) Age group 50-64

Source: SHARE, wave 1, release 2

3.2.2 Volunteer work and education

Volunteering increases by education. On average, volunteering is three times as common among high educated (18% volunteered) than among low educated (6%). The possible explanations are that higher education builds self-confidence and provides ways to participate. Also, higher educated people might be more often asked to join to various organizations.

Table II.57: Participation in Volunteer Work by Education and Employment Status (age group 50-64)

Country	Education Low	Education Medium	Education High	Working	Retired	Other non-working
CH	10.5	16.4	19.7	15.4	10.6	22.5
DE	4.8	8.7	16.9	10.5	8.7	12.6
DK	12.1	16.2	23.7	17.4	17.2	20.4
EL	1.8	(.)	7.8	4.6	2.9	(.)
ES	(.)	(.)	(.)	(.)	(.)	(.)
FR	9.6	14.8	23.0	11.4	15.0	12.3
IT	5.1	12.2	(.)	12.4	7.0	4.1
NL	18.6	20.3	29.1	19.3	20.3	23.1
AT	5.4	9.4	13.7	13.2	8.4	7.1
SE	14.3	18.6	22.9	18.7	16.3	(.)
All	6.3	10.8	18.3	11.3	9.5	8.9

Source: SHARE wave 1, release 2

3.2.3 Volunteer work and health of volunteers

On average, volunteering is more common among those who have at least fair health than among those whose health is deteriorated (see next Table). However, in some countries the differences in volunteering by health status are minor or those who have bad health volunteer even more often than people in better health.

Table II.58: Percentage of Europeans who has done volunteer or charity work by country, sex, and general health (age group 50-64)

Country	Men					Women				
	Health status					Health status				
	Very good	Good	Fair	Bad	Very bad	Very good	Good	Fair	Bad	Very bad
AT	21	12	5	10	0	7	8	5	0	0
DE	9	14	11	17	0	16	12	13	9	0
SE	33	21	25	12	0	17	8	14	9	25
NL	17	19	13	27	50	22	32	28	14	0
ES	0	3	2	6	0	3	4	5	0	0
IT	7	11	9	13	0	17	10	7	0	0
FR	14	23	10	16	0	0	15	15	11	5
DK	17	15	26	8	14	19	9	10	18	0
EL	3	3	5	0	0	2	3	8	18	0
CH	23	9	6	0	50	21	23	20	33	-
BE	25	20	20	11	0	18	16	16	8	0

Source: Share wave 1 release 2

As noted, better health favours volunteering and on the other side, volunteering may contribute in maintaining good physical and mental health.

3.2.4 Volunteer work and working hours

The average of working hours in gainful employment is smaller among volunteer workers than among people who do not participate in volunteer or charity work. Particularly this is the case for women in all countries included in the SHARE study (see next Table). However, the difference in working hours was less than an hour for Sweden and Greece, while, on the other hand, in Italy and Switzerland the women who participated in volunteer work, worked almost 10 hours a week less than women who did not volunteer – an amount that is visibly above the average. For men, the effect of participation in volunteer work on working hours was less apparent. On average, their working week in gainful employment was shorter only by half an hour. Exceptions were Italy and Denmark where volunteer work deducted the working hours by several hours. On the other hand, men who volunteered worked more hours in gainful employment than those men not volunteering in Austria, Sweden, Spain, France and Switzerland. The difference in working hours by participation in volunteer work in different countries and genders can possibly be accounted for the different type of volunteer work done and different types of support available.

Participating in volunteer work is very seldom a substitution to gainful employment. Doing volunteer work is almost as common whether a person is employed or non-employed due to retirement or other reasons (see next table).

Table II.59: Average worked hours by country and sex and participation in volunteer or charity work. (age group 50-64)

	MEN			WOMEN		
	participants	Non-participants	difference	participants	non-participants	difference
Country						
AT	44,78	44,12	-0,66	31,68	34,14	2,46
DE	41,42	43,36	1,94	25,02	30,79	5,77
SE	42,43	41,18	-1,25	36,06	36,23	0,17
NL	39,67	39,80	0,13	20,65	25,98	5,33
ES	41,67	40,09	-1,58	26,57	34,41	7,84
IT	36,27	40,30	4,03	22,00	31,56	9,56
FR	41,44	41,34	-0,10	33,09	34,35	1,26
DK	37,08	40,55	3,47	31,88	35,01	3,13
EL	39,11	39,31	0,20	33,68	34,27	0,59
CH	43,50	42,23	-1,27	20,74	30,54	9,80
BE	41,09	41,87	0,78	28,87	30,91	2,04
Total	40,77	41,29	0,52	28,20	32,56	4,36

Source: SHARE, wave 1, release 2

3.4 Conclusions

As it was noted in the previous parts of this report, activity and health are closely correlated. Activity may take different forms.

The number of people participating in clubs in Europe:

- is lower in southern European countries (Greece, Spain and Italy)

- the percentage is generally lower for women compared to men
- the participation in such activities seems to decrease with age.

Participation in education and training is important for cognitive performance and a healthy ageing. We may note:

- participation is lower for Mediterranean countries
- participation is often higher for women than for men
- participation in such activities decreases with age
- the oldest declare going more at daily and weekly course. The “youngest” declare going more at a monthly course.

Vigorous activity is less frequent than activities requiring a moderate level of energy among the elderly. We can see that women do less often vigorous activities than men. For moderate activities it's more or less the same incidence for men and women.

Concerning volunteering, we may note the following:

- The level of volunteering varies between countries
- Informal care decreases both the need for formal volunteering as well as opportunities to volunteer for the family members
- There are only minor differences in volunteering between females and males
- Among volunteers, females and males contribute as many hours
- Females and males can, however, be interested in different types of volunteering
- Volunteering centres on culture and in organizations working in social and health sector
- Those who volunteer do that very frequently
- Volunteering increases with education

Concerning volunteering and employment, we may note:

- The average of working hours in gainful employment is smaller among volunteer workers than among people who do not participate in volunteer or charity work.
- this is notably the case for women in all countries included in the SHARE study
- Participating in volunteer work is very seldom a substitution to gainful employment.
- Doing volunteer work is almost as common whether a person is employed or non-employed due to retirement or other reasons.

Concerning the association between volunteer work and health, volunteers are found to have relatively good health; however, one has to keep in mind that in certain cases good health might be a factor enabling volunteering.

In some countries the differences in volunteering by health status are minor or those who have bad health volunteer even more often than people in better health.

II.4. Labour market participation and informal caring

4.1 Introduction

Part I has shown that the number of hours spent caring has important impacts on labour participation. Difficulty in combining paid work and informal care seems to particularly affect those undertaking substantial hours of caring per week. It is when caring is intensive that carers find it increasingly difficult to remain in paid employment. The conclusions of the literature showed that the intensity of provided care was an important factor on the probability of labour participation.

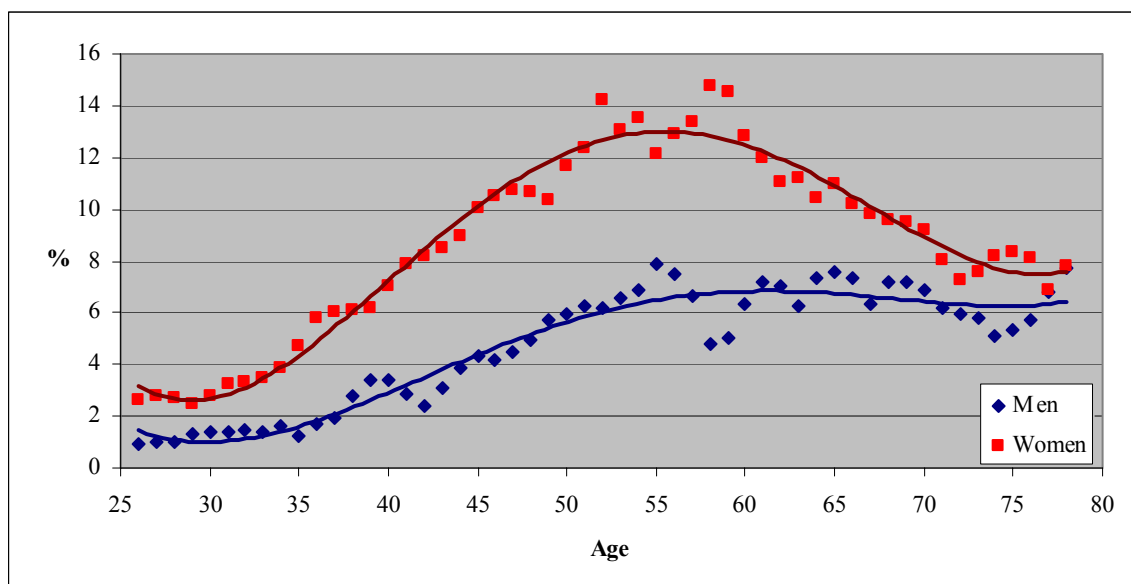
In this chapter we will analyse the characteristics of carers, the quantitative importance of caring, the intensity of caring and its impact on labour participation.

We will also analyse the impact of caring on the health of carers.

4.2 Characteristics of carers

Concerning gender distribution, available data indicates that the vast majority of carers are women. The share of women varies between 60% and 80%. If we focus only on people caring for elderly persons, the share of women varies between 67% (Ireland) and 80% (Austria).

Figure II.60: Percentage of persons looking after a person (who needs special help because of old age, illness or disability, other than a child) by age. (As a % of same age group)

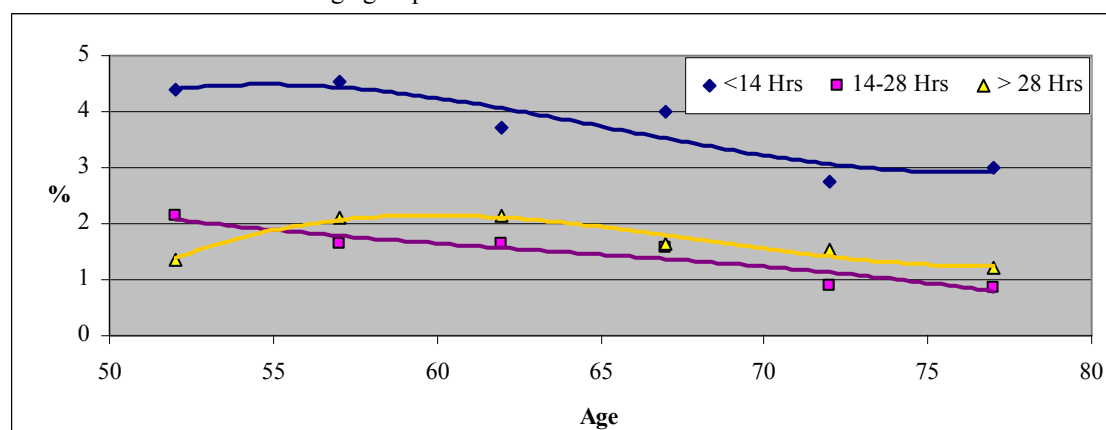


Note: The points are 3 year moving averages.
Source: ECHP UDB 2001

It is interesting to note that a high number of carers are in the age group of 55-64, where labour participation is low. Furthermore, people caring for 35 hours per week or more may be considered as the main providers of help. This is not sure for persons caring for less than 28 hours per week. This is important for the carer, as this might mean that his help has an occasional supportive role and thus a greater flexibility in organising it.

Figure II.61: Persons looking after an adult (who needs special help because of old age, illness or disability)

As a % of the same age group



Note: The total of the 3 levels is equal to the previous table.

Source: ECHP UDB 2001

The amount of time spent caring differs widely between the countries of the sample. Whereas the number of persons providing help outside the household is highest in Denmark and Sweden for low quantities it is lowest when it comes to the category of 20+ hours per week.

Table II.62: Hours of care given by the helpers (age group 50-64)

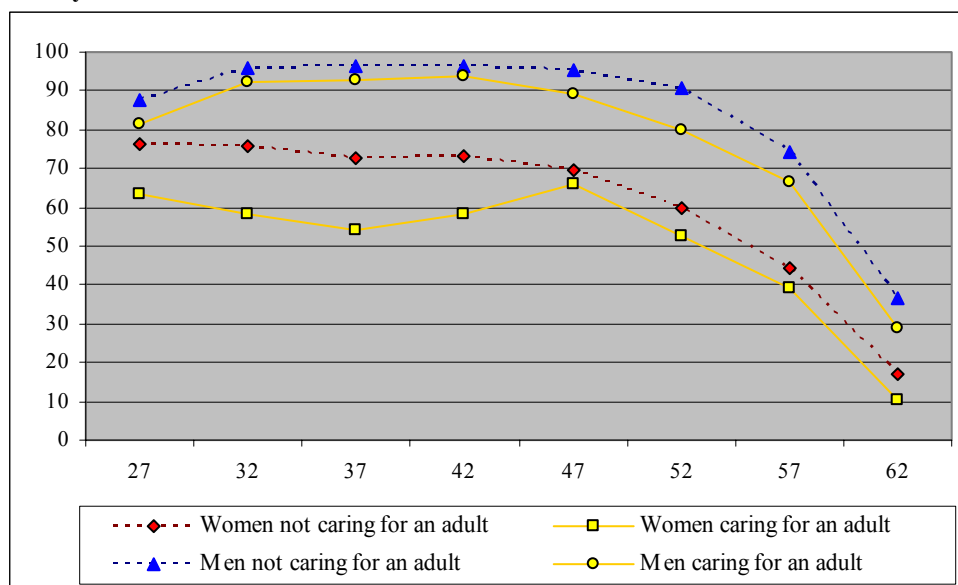
Hours	[<1]		[1 to3]		[3 to5]		[5 to10]		[10 to 20]		[20 to 40]		[40 to 84]	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W
AT	31	26	25	16	10	13	15	10	6	19	12	9	1	7
DE	45	33	24	20	10	14	9	11	5	10	6	9	1	3
SE	52	43	22	25	12	11	9	11	3	6	0	3	0	1
NL	51	31	19	21	10	15	12	16	5	8	2	7	1	2
ES	53	35	14	10	3	11	8	12	10	11	9	13	3	8
IT	43	25	13	11	11	10	8	10	10	16	11	14	4	14
FR	52	41	18	23	9	9	12	13	5	8	3	4	1	2
DK	51	43	26	27	6	11	7	10	8	7	1	1	1	1
EL	45	33	17	10	7	8	18	17	9	12	3	2	1	8
CH	43	39	28	24	9	11	12	10	4	7	3	6	1	3
BE	37	27	23	17	9	10	16	19	8	13	5	10	3	4

Source: Share (2004) wave 1 release 2.

4.3 Caring and employment

Caring responsibilities and labour market participation might compete for available time budgets. It can be observed that caring for an adult decreases labour market participation (notably for women). This is particularly clear in ages where child rearing might be an additional time constraint. In some countries this relation is striking while in others it is minimal.

Figure II.63: Percentage of persons participating on the labour force (employed or unemployed) by sex and whether they look after an adult or not

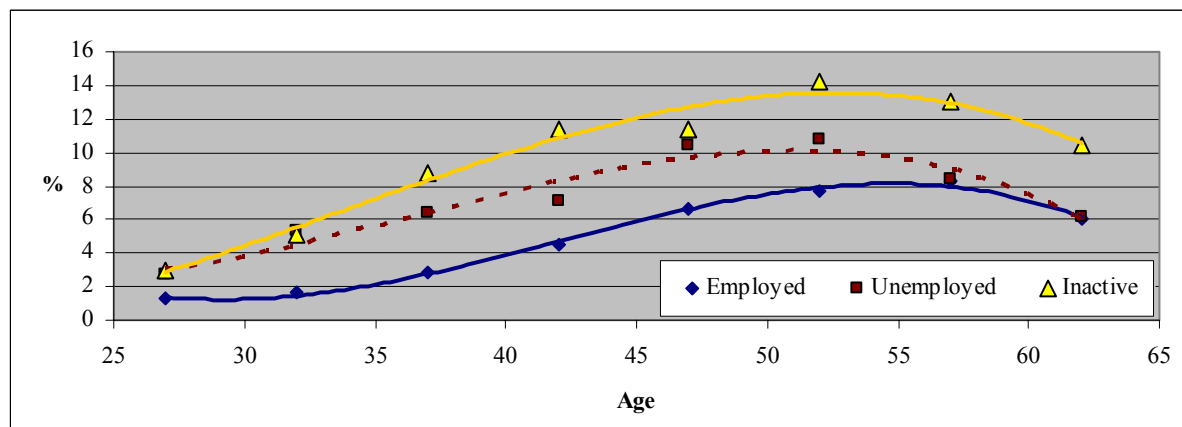


Source: ECHP UDB 2001

Caring affects women's labour market participation stronger than men's. Labour market participation of women is lower than men's in general.

As noted in the review of the literature, unemployed and part-time workers may assume the role of carer more easily inside a family. On the other hand, an informal carer has to combine work and care giving. Consequently, he might be pushed into part-time jobs.

Figure II.64: Persons looking after an adult (who needs special help because of old age, illness or disability) by age and economic status. (As a % of the same age group)



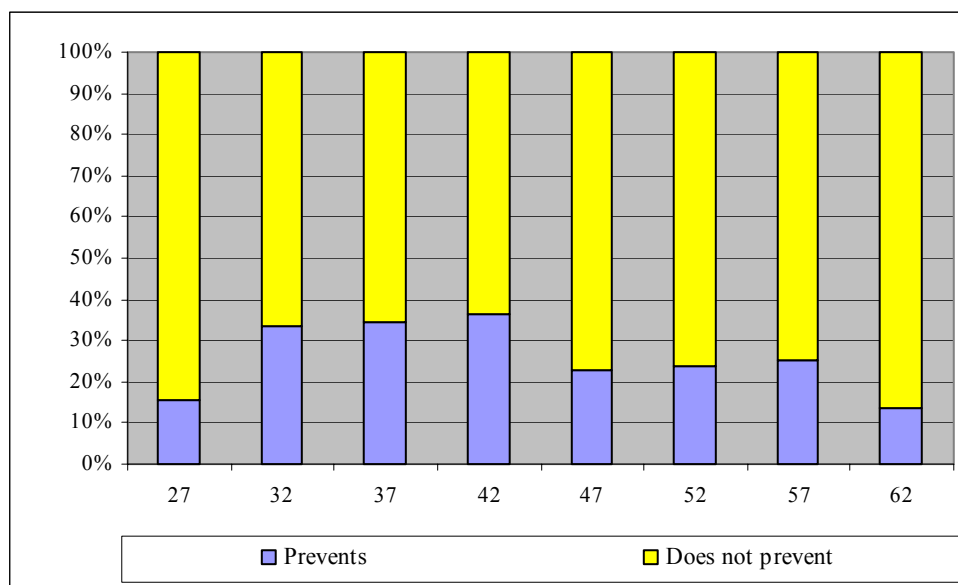
Source: ECHP UDB 2001

In addition to part time work, "inactivity" has to be considered when looking on labour market statistics and care. The status 'inactive' is applied when people of working age are neither gainfully employed nor registered as unemployed.

The percentage of inactive providing care to adults is higher compared to employed people.

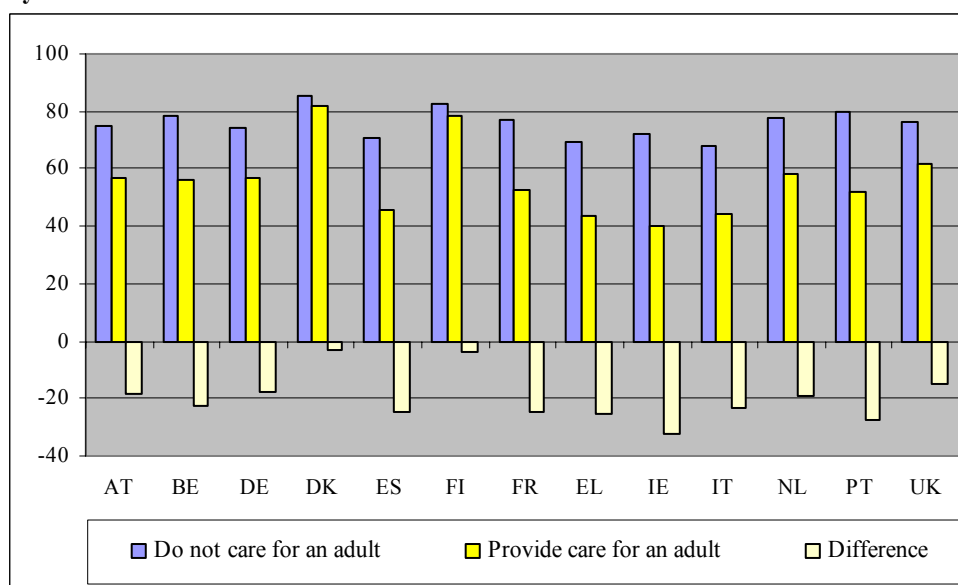
About 25% of persons looking after children or adults declare that this prevents them from undertaking the amount or kind of paid work which they otherwise would do.

Figure II.65: Looking after children or other persons prevents from providing desired amount or kind of work



Source: ECHP UDB 2001

Figure II.66: Percent of persons participating on the labour force (employed or unemployed) by sex and whether they look after an adult or not



Source: ECHP UDB 2001

In Denmark and Finland overall labour market participation is very high for both carers and non-carers, the difference is minimal. The difference in labour market participation between carers and non-carers is relatively low also in the UK, Germany, Austria, and the Netherlands.

It is true that countries with the highest labour market participation also have the highest rate of working informal carers (Denmark, Finland). However, general high labour market participation does not imply a high labour market participation of carers (e.g. Portugal, France).

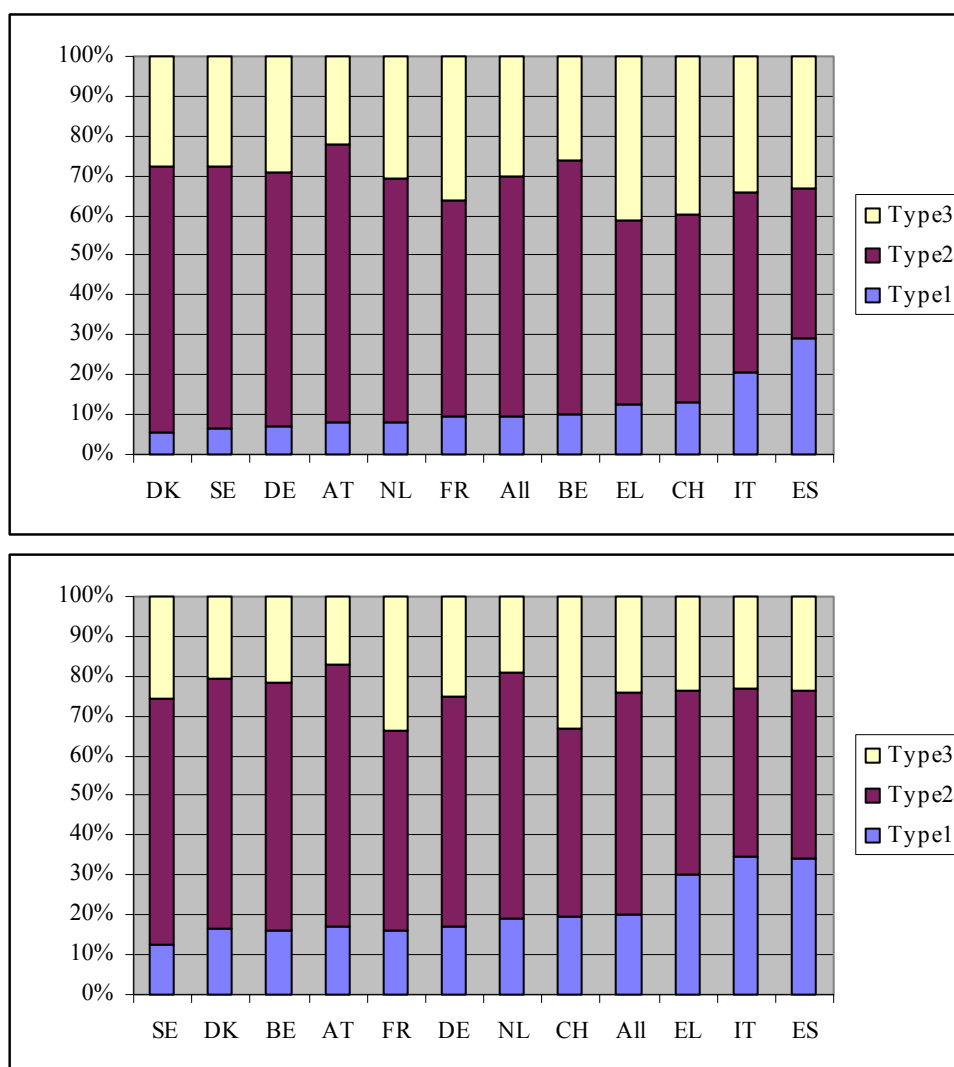
In Denmark, labour market participation of both men and women is very high in general. Also, the participation rate of carers is very high.

It has also to be considered that in comparison, informal carers in Denmark provide less demanding help than carers in other countries of our sample. “Personal care, e.g. dressing, bathing or showering, eating, getting in or out of bed, using the toilet” was provided only by 14% of carers (7% men, 21% women) whereas these figures are 48% for Spain (42% men, 54% women).

There is a clear difference between men and women. Women provide relatively more demanding help than men. The proportion of Type 1 (personal care), generally provided to dependent persons is higher among women compared to men.

There is a clear difference between Southern and Nordic countries. The importance of Type 1 (personal care) is much more important in Southern countries, both for women and men. This might reflect the low institutionalisation rate in these countries. Also, having elderly people living in the same house as younger generations, means less help concerning Type 2 (notably home repairs, gardening, etc.).

Figure II.67: Types of help given (age group 50-64)



Note: 3 types of help (non exclusive) were proposed: Type1: Personal care, e.g. dressing, bathing or showering, eating, getting in or out of bed, using the toilet; Type2: Practical household help, e.g. with home repairs, gardening, transportation, shopping, household chores; Type3: Help with paperwork, such as filling out forms, settling financial or legal matters.

As the types of help are non exclusive and the totals higher than 100%, we had to adjust them to summarise to 100.

Source: Share (2004) wave 1 release 2

In general, conditions for carers to combine work and care – or family life in general – are looking good in Denmark. The wide provision of services to dependent people might explain the Danish situation. Policies clearly prioritise gender equality and high labour market participation over cost reduction in care.

The following figures show that part time work is more common for women than men. This is independent from care obligations.

Table II.68: Average worked hours for Europeans who gave or not help outside the household by country and sex (age group 50-64)

	HELPERS		NON HELPERS	
	Men	Women	Men	Women
Country				
AT	42,83	31,29	45,06	35,30
DE	44,56	31,65	42,04	29,07
SE	41,95	36,63	41,02	35,70
NL	40,16	24,18	39,33	25,12
ES	38,91	34,97	40,35	33,88
IT	37,90	29,90	40,97	31,52
FR	40,52	35,67	41,74	33,24
DK	38,88	34,37	41,20	34,72
EL	38,69	32,29	39,49	35,19
CH	42,89	27,56	42,14	29,31
BE	40,88	29,71	42,67	31,67

Source: Share (2004) wave 1 release 2.

Table II.69: Average worked hours for Europeans who gave or not help inside the household by country and sex (age group 50-64)

	HELPERS		NON HELPERS	
	Men	Women	Men	Women
Country				
AT	42,17	32,19	44,34	33,48
DE	44,64	30,62	43,49	29,68
SE	39,72	37,81	41,74	36,33
NL	37,47	27,55	39,90	23,98
ES	40,38	35,38	40,09	33,76
IT	37,52	29,86	39,98	30,96
FR	41,79	37,47	42,05	34,19
DK	43,00	31,57	39,98	35,02
EL	36,33	33,38	38,64	34,36
CH	42,50	15,75	42,31	27,79
BE	45,71	28,71	41,84	30,75

Source: Share (2004) wave 1 release 2.

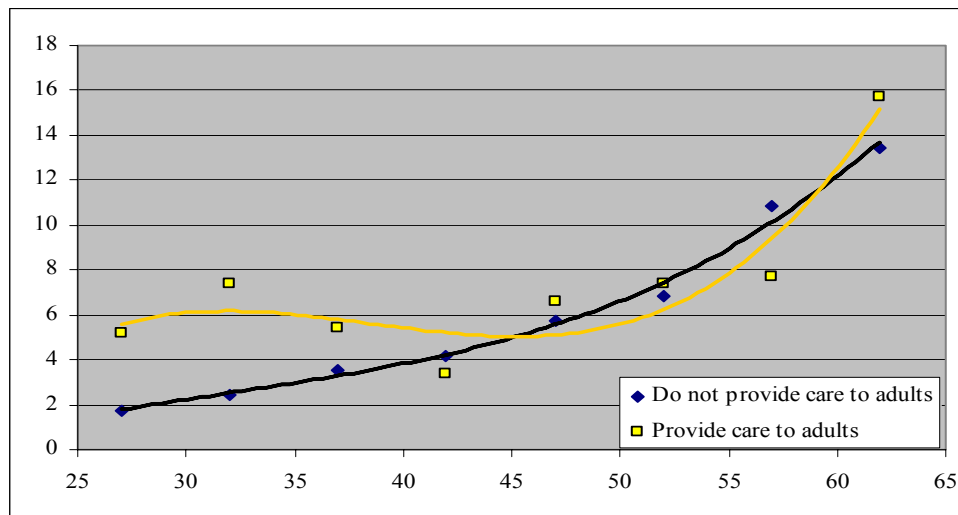
4.4 The health of carers

Caring brings several constraints to the carer. This might have an adverse impact on his/her health. In the following, we will analyse the health of carers.

In order to avoid the justification bias, we consider only employed persons in our analysis.

The impact of providing long term care to an adult has an uncertain impact on carer's health.

Figure II.70: Percent of employed persons declaring bad or very bad health by whether they look after an adult or not



Source: ECHP UDB (2001)

For the age group 30-35, there is a clear deterioration which might be the result of cumulating care for children and care to adults. Opposite but weaker results were found for the age group from 47 to 60.

4.5 Conclusion

Characteristics of carers:

- Available data indicates that the vast majority of carers are women.
- A high number of carers are in the age group of 55-64, where labour participation is low.
- The amount of time spent caring differs widely between the countries of the sample.
- Whereas the number of persons providing light help outside the household is highest in Nordic countries it is lowest when it comes to the category of 20+ hours per week.

Caring and employment

- Caring responsibilities and labour market participation might compete for available time budgets
- Caring for adult decreases labour market participation (notably for women). This is particularly clear in ages where child rearing might be an additional time constraint.
- Caring affects women's labour market participation stronger than men's. Labour market participation of women is lower than men's in general.

- Unemployed and part-time workers may assume the role of carer more easily inside a family.
- An informal carer has to combine work and care giving. Consequently, he might be pushed into part-time jobs.
- The percentage of inactive providing care to adults is higher compared to employed people.
- About 25% of persons looking after children or adults declare that this prevents them from undertaking the amount or kind of paid work which they otherwise would do
- In Denmark and Finland overall labour market participation is very high for both carers and non-carers, the difference is minimal.
- Informal carers in Denmark provide less demanding help than carers in other countries of the sample.
- There is a clear difference between men and women. Women provide relatively more demanding help than men. The proportion of Type 1 (personal care), generally provided to dependent persons is higher among women compared to men.
- There is a clear difference between Southern and Nordic countries. The importance of Type 1 (personal care) is much more important in Southern countries, both for women and men.

The health of carers:

- Caring brings several constraints to the carer. This might have an adverse impact on his/her health.
- The impact of providing long term care to an adult has an uncertain impact on carer's health.
- For the age group 30-35, there is a clear health deterioration which might be the result of cumulating care for children and care to adults.

PART III

Cross country comparison of national approaches

Introduction

Part I and II have presented existing studies and data of a certain number of themes. Progressively, we retained those aspects which could form the base of national and European policies.

In this part, we present national policies on the following themes:

1. Health and labour market participation
2. Financial (dis) incentives
3. Active and healthy ageing, and
4. Long-term care

We describe first the main developments in a selected number of Member States and then present the similarities and differences across the chosen countries.

III.1. Health and labour market participation

1.1 Introduction

The previous parts have shown that there is a big potential labour force supply of older non-working population in Europe as a significant proportion of them would like to work. However, traditional approaches view health problems as a channel to early retirement and inactivity.

Several chapters have led to the conclusion that part-time work is desirable for older workers with health restrictions, notably for people with health problems, persons desiring to reconcile work and care provision, workers desiring phased retirement, etc.

In the following, we will analyse national policies focussing on age management and part-time for people with health problems.

1.2 Health and age management

1.2.1 National policies

In the following, we present national policies focussing on health of older workers and describe initiatives at national and at company level.

Belgium

Policies are relatively recent and need to reinforce their complementarity and coherence.

In 2002 the government established a Fund to promote better working conditions for over 55. Funds can be granted to companies for the improvement of working conditions of their elderly workers.

At the federal level, measures of “credit-temps” were introduced. This programme allows workers 50 years old or more to reduce their working time of one day or two half days in the week (for a six month period minimum) or to pass at part-time work.

The Flemish region introduced the ‘Zilverpas’ programme. It aims to promote the employment of older workers. Taking into account the age of workers, this program aims to stimulate a good human resources management. Companies with projects may ask for subventions to finance them. In autumn 2002, 120 companies asked for financial support. In 2001, they were only 10 to ask for it.

The Brussels Region (French community commission) has signed a sectoral agreement with the non-profit sector. It provides for the adaptation and reduction of working time of workers aged 50 or more.

Denmark

Denmark has developed a wide range of initiatives and approaches at different levels. There is a general policy to meet the potentialities of older workers and jobs requirements (notably through rotation of workers between tasks - in less physically demanding tasks and part-time). The policy focus is the worker himself.

The National Market Authority is supporting employers to introduce senior policies at the firm level. This is mainly done by the Senior Policy Consultant Scheme, which finance five hours of consultancy assistance to firms that want to introduce senior policies. Good practices are proposed to firms.

The Danish employers' confederation defines senior policy as organisation's personnel policy which aims to:

1. Increase the possibilities for workers to remain an attractive, qualified and flexible work force during their entire working life;
2. Increase the possibility for elderly workers who wish to remain at their place of work instead of retiring;
3. Increase seniors' possibility to remain employed in the firm.

More than every second firm (50%) employing elder workers has a senior policy offering. The offerings may consist of reduction of requirements to the worker (shorter working hours or less demanding tasks) or increasing the worker's resources (vocational training) .

Danish trade-unions have been proactively engaged in negotiating the implementation of age management and, in particular, of better working conditions.

For Denmark, higher participation rates could also be facilitated by rehabilitation measures and by subsidising the employment of persons with a reduced working capacity. For example the "flexjobs" program aimed to make room for people with limitations in their working capacity but who are still able to work.

The Law on Active Social Policy (1998) provides for vocational rehabilitation and 'flexjobs'. Flexjobs are jobs with wage subsidies of 25%, 50% or 75% of the minimum wage (the 25% band was eliminated in 2003). The target group is persons with a permanently reduced work-ability who are not entitled to pre-pensions. The person in a 'flexjob' receives wage according to collective agreement. The employer pays the normal wage to these people, and the local authority pays the employer a subsidy covering half or two thirds of the wage. Employers may be public or private enterprises. There are also 'protected jobs' which carry a 50% subsidy, where the person works for 1/3 of normal time.

There is, however, rising critical concern regarding substitution of regular jobs and the lack of some general labour market rights for 'flexjobbers', for instance the exclusion of flex-jobbers from regular unemployment insurance. Such critics hint to a general problem of trading-off flexibility and security of an employment.

Another interesting aspect of Danish practice is vocational training. In Denmark a very large number of enterprises offer a large share of their employees continuing vocational training courses of comparatively long duration. Furthermore, in Denmark, older unemployed workers benefit from good opportunities to participate in continuing vocational training as an element of an "individual activation plan". There is an institutional cooperation between state, enterprises and trade unions and the government brings an important financial support to projects for continuing vocational training of employees and unemployed persons. In 2004, Denmark increased the maximum age limit up to 64 for the training and retraining of unemployed persons.

Germany

The Government focuses on rehabilitation measures and favours legal instruments. Recently, rehabilitation has been completed by efforts towards companies. Mandatory agreements are signed with social partners to co-ordinate actions concerning qualification, employability, age-adjusted working time regulations and job promotion for older workers.

The German policy centres on disability management. The general strategy focuses on actions around occupational illnesses and injuries. Consequently, this approach presents some limitations. Older

workers with health problems not related to work may find themselves in a less favourable position concerning reintegration measures.

The German Social Code Book IX (SGB IX) regularised in 2004 operational measures to integrate disabled people into work, through the following:

- a) Integration Agreements
- b) Operational Integration Management

The first strategy is based on agreements between the employer and social partners for the severely disabled. It identifies certain aims to be achieved, e.g. proportion of disabled within the company, workplace conditions, working hours, special conditions for women/people with children, measures for health promotion. This agreement is only valid for disabled employees, whereas the second strategy, the Operational Integration Management, is helpful for all employees.

On this model, we can do two comments. Although the Integration Agreements are compulsory, employees do not show much interest in them yet (Niehaus/Schmal 2005, 253). Integration Agreements are only relevant for disabled people.

The general policy relies on reintegration actions initiated by public institutions. The desire to involve employers and to sensitize them is recent.

As noted, the Government aims to maintain (older) people with light health problems in the labour force through the promotion of Public-Private partnerships (example for a major company: Ford Motor Company, Cologne – Germany, and small and medium-sized enterprises)

The German experience with small and medium sized enterprises revealed notably that:

- Uniform external support is necessary to provide the services needed, by e.g. grouping of several companies located in one area to create Disability Management teams and the networks / round tables with external partners, such as health / accident insurances etc. (Hetzel et al. 2006).
- Small and medium sized enterprises need support by external staff while big enterprises can release their own staff for these tasks (Biermann 2007).
- In Germany Integration Services– specialised in promoting disabled people to find and keep work – are able to play the role of the external partner for small and medium sized enterprises. Up to today they are not that much involved as they could be. The concept is very suitable to be transferred to the target group of older employees (Gerdes 2007).

In 2003 the German employers' association, BDA (2003), published a guide on age management at company level. It provides explanations on the rationale of employing older workers and the required measures at company level, in combination with information on public programmes for older workers. The Guidelines particularly addresses how to adjust work tasks to older workers, as well as aspects of HR policies, like continuing training, working time arrangements and age-mixed team building.

Spain

The policy is fragmented and narrow. Only recently some initiatives have taken place. They centre on financial incentives.

Employers are eligible for a 50% or more reduction in social security contributions for employees over the age of 60 who have five years of seniority and are employed on permanent contracts. The reduction increases by 10% per year.

Workers aged 65 and over (who have contributed for 35 years) and their employers are exempt from paying social security contributions, except those relating to temporary incapacity.

France

In France, recommendations focus on improving working conditions and adapting jobs to the abilities of older workers.

The first initiatives focussed on working conditions and only recently the centre is shifting towards the older worker himself.

France created the « Fonds pour l'amélioration des conditions de travail (FACT) » (Fund for the improvement of working conditions) which aims to help companies with subventions for:

- Preventive actions against professional's risks
- Actions related to age management taking into account the hardship of work on health of older workers

Reformed in 2005, the FACT is now only available for tiny and middle companies. The FACT has also refocused on age management.

In 2006, a program for the employment of older workers has been presented by the French government. In this 2006-2010 program, guidelines include notably:

- keeping older workers at work
- if an older worker is declared disabled, he should have the opportunity to find another job less physically demanding.

In France, collective bargaining on age management issues is developed in parallel with arrangements for early retirement.

Netherlands

In the Netherlands, most reforms focussed on disability pensions and few provisions centred on the improvement of the employability of the older workers. These provisions began only after 2000. The efforts related on training and information campaigns, in order to change mentalities of the employers and employees as for competences and the know-how of the older workers.

Recent measures emphasized the reduction of disability beneficiaries. The old "Disablement Insurance Act" entitled disabled employees under the age of 65 to a benefit, if they were at least 15% unfit for accepted employment. The new "Work and Income According to Labour Capacity Act" covers since 2006 all risks of inability to work above an occupational disability level of 35%.

The new Act is applied following two years of the employee's illness. During the first two years of illness, rehabilitation and return to work of the employee will be the responsibility of the employer and the employee themselves. The goal was to make employer responsible for the vocational reintegration of the employee. Also, it was considered that companies with high work accidents ought to bear the cost of rehabilitation. The new law contains incentives for rehabilitation aimed both at the employer and at the employee.

All Dutch workplaces must have a prevention contract with occupational health services. The latter determine whether the employee is fit for work or needs long-term absence assistance. They provide advice on preventing such absence.

In 2001, the Ministry of Social Affairs and Employment set up a temporary taskforce on older people and employment, whose mission was to identify and communicate ways of keeping older workers in the labour force for a longer period of time. Proposals concerning adjusting work included notably, regular job rotation; investing in one's own healthy workplace, body posture and exercise at work; and integrated health management (set of practices to keep employees healthy).

In the case of the Netherlands, State initiatives have been successful in promoting collective bargaining on age-related issues.

The Dutch system has shifted in the past responsibility for health and disability management from the State to the employer. The employers had to share a high cost for absence days. Recent initiatives tend to reverse this policy. Disability legislation and social partners agreements indicate that the system caters relatively well for people with chronic illness.

Poland

A series of initiatives are being applied to highlight the added-value of older workers' knowledge and experience, and therefore making use of their skills even after retirement age, and ensuring the transfer of knowledge to younger generations for highly qualified jobs (training of young professionals by older experienced workers even after their retirement). The working conditions are adapted to the needs of older workers, in terms of ergonomic working environment, flexible working hours, lifelong learning and rehabilitation programmes.

Finland

Finland provides a wide range of services ranging from prevention to reintegration. The legislation and social partner agreements support the worker and the employer. Support focuses on health promotion, health and safety at work, risk management and reintegration in the company. The Occupational Illness Act covers mental illness from workplace stress.

Finland has a well developed workplace health management approach. Legislation requires employers to: provide a safe and healthy workplace; undertake medical examinations if a job poses special health hazards; provide occupational health services for employees; and monitor the ability of disabled workers to work. Employees can request an assessment of their mental and physical workload. Maintenance of Work Ability emphasises early return to work⁷⁸.

Because Finland has a long tradition of early retirement through disability pensions, many of the early retirement programs were largely directed to health related matters. Some examples of these were "Respect for work ability" and "Work ability for tomorrow" introduced by the Federation of Employment Pension Institute, "Respect for the Ageing" introduced by the Finnish Institute of Occupational Health and "Fitness for All Ages" introduced by the Ministry of Education and the Ministry for Social Affairs and Health.

Finland developed a National Program on ageing workers from 1998 to 2002. This program was implemented jointly by the Ministry of Social Affairs and Health, the Ministry of Labour and the Ministry of Education. The interaction between these three Ministries made possible reforms that touch every aspect of the working life of older workers like longer working careers, quality of work, continued training, working capacity improvement, legislative measures, health prevention, and so on.

The Finnish Ministry of Social Affairs and Health and the Finnish Institute of Occupational Health launched a joint project in 2005, "Health in the World of Work – Prolonging Healthy Working Years".

⁷⁸ Richard Wynne and Donal McAnaney; Employment and disability: Back to work strategies; European Foundation for the Improvement of Living and Working Conditions, 2004

The recommendation focussed on four areas: workers' health in all policies; a healthy enterprise; making services accessible to all; and innovations needed to achieve better work life.

To increase the attractiveness of working life and improve the health and fitness of the working-age population, a new program called "VETO" was introduced by the Ministry of social Affairs and Health in 2003. The goals of the VETO program are to ensure that people can fully participate in working life, encourage them to stay longer at work and enhance the attractiveness of work. The program is divided into four parts: attitudes to safety; occupational health care and rehabilitation; diversity and equality at work; and income security and time in work.

In Finland, to prevent the exclusion of seniors from the labour market, various measures concerning the preservation of the physical and mental abilities, as well as the preservation and the transmission of the skills, are encouraged: arrangement of schedules, part-time, training, leaves of formation (training), tutelage, adaptation of jobs. The employers can be advised by psychologists and ergonomists. Certain companies go even further by offering supplementary days off to their employees approaching the retirement age.

Finnish trade-unions have been proactively engaged in negotiating the implementation of age management and, in particular, of better working conditions. A typical feature for the Finish approach to the age challenge is to run Programmes based on broad cooperation between ministries, expert organisations and social partners.

A project of the Finnish Occupational Health Institute on networking was promoting good practice in age management in SMEs and was establishing a network of 'knowers and doers'.

Sweden

The Swedish government did its 11 points program for better health in working life (Ministry of Health and Social Affairs, 2001). This program focuses on measures for a better working environment and clearer employer responsibility as well as measures for an early return to work after illness. It provides more of a framework for measures rather than a ready-made package of specific measures to be implemented immediately. The program is carried out in close connection with the social partners.

In the public discussion the older workforce dilemma is articulated in the following key areas:

1. Growing concern about the rise in long-term sickness absence in the labour force due to the costs it generates,
2. Move to increase flexibility of work conditions, e.g. in terms of flexible working hours, part-time work etc. Employers are encouraged to develop "learning organizations".
3. Changing attitudes towards older workers.

There are two major strategies:

- 1) A strategy of decisive institutional change, where the pension system is changed in order to create strong incentives to continue to work longer, notably by closing some of the exit paths.
- 2) Measures to adapt jobs to the demands of individual flexibility, as well as laws forbidding employers and unions to agree on mandatory retirement at 65, and an increasing government pressure on employers to enter more actively into the rehabilitation arena.

An adverse impact has been noted. Since this policy shifts much of the economic cost of rehabilitation on employers it may also, paradoxically, increase the exit pressure.

Swedish trade-unions have been proactively engaged in negotiating the implementation of age management and, in particular, of better working conditions.

United Kingdom

The UK is characterised by a wide range of recommendations, global programmes and information campaigns.

Occupational reintegration and working conditions constitute a first important axe. Enabling people to continue working after illness or injury is a key part of the Department for Work and pensions (DWP) objectives. In co-operation with the Health and Safety Commission and the Health and Safety Executive, the DWP hopes to reduce the number of working days lost per 100 000 workers from work-related injury and ill-health by 30% and the incidence rate of cases of work-related ill health by 20% by 2010. Consequently, the government has embarked on a series of initiatives and program to address the problem. The government's initiatives are a key component to ensuring that illness and injury do not permanently reduce individuals' employability.

For example, we can mention some government initiatives to reduce work-related ill-health. Work-life Balance is a campaign launched in 2000 to help employers recognise the benefits of adopting flexible working patterns that enable individuals to balance better aspects of their work and life.

Job retention and rehabilitation pilot is a program introduced in 2003 by the DWP and the Health department in order to test the effectiveness of helping people to get back to, and to remain in work.

Securing health together (Healthy working lives is the Scottish equivalent) is a long term program which concerned occupational health and other interested parties outside government to work together to reach the following common goals by 2010: to reduce ill-health caused or made worse by work; to help people who have been made ill, whether caused by work or not, to return to work; to improve work opportunities for people currently not in employment due to ill-health or disability; and to use the work environment to help people maintain or improve their health.

The "New deal 50 +", set up in 2000, consists in building individual plans on returning to the labour market for most than 50 years and take into account explicitly the lack of skills or still health problems. Since 2003, the New deal 50 + is offered on a voluntary base to all the beneficiaries of social-security benefits and permit to obtain a generalized tax credit the duration of which is carried in 12 months. The English government promotes the improvement of the working conditions of seniors and the development of the working time and considers the problem of non discrimination and variety of the manpower as a condition of increasing employment rate.

1.2.2 Comparative analysis

European countries encourage age oriented policies both at national and company level. We may note:

- Denmark focuses on work environment (requirements) while Sweden promotes incentives to continue working with better working environment;
- Germany focuses on rehabilitation;
- Germany and France adopt a disability approach;
- Netherlands focuses on improving the disability pension schemes;
- Finland adopt a global health approach;
- France and the UK favour improvements in working conditions.

Nordic countries and in particular Denmark, Finland and Sweden have invested in health management of older workers through many programs and policies. These policies and programmes favour the transfer of older workers to less physically demanding tasks, part-time, ergonomics, etc. The adaptation of working time (part-time work) seems to be a preferred road for most countries.

These countries aim to reach companies and favour an active participation of employers. They promote a consensual approach between all involved parties. Consequently, approaches to sensitize employers are of a big importance. In the case of the Netherlands and of Finland, State initiatives have been successful in promoting collective bargaining on age-related issues.

Working conditions and ergonomic aspects have been favoured by most countries. In addition, France and Belgium have focussed on financing the improvement of working conditions.

Table III.1: Summary of key national instruments / policies

Country	Instrument / Policy
BE	Better working conditions for over 55. Stimulates a good human resources management. Promotes part-time and stay in employment in less physically demanding jobs.
DK	Adapt jobs. Support employers to introduce senior policies at the firm level. "Individual activation plan". Social partners' involvement. Tripartite efforts for vocational training.
DE	Rehabilitation and legal instruments. Public-private-partnerships. "Disability management".
ES	Financial incentives to employers.
FR	Funds for improvement of working conditions. 2006-2010 Programme (focus on disability).
NL	Focus on disability pensions. Integrated health management. The employer has a responsibility for rehabilitation.
PL	Segmented initiatives.
FI	Health plays an important role. Focus on job design, human abilities and work environment. Strong cooperation between different policy actors. Continuum of services.
SE	Program for better health in working life. Incentives to continue work longer and better working environment. Employer responsibility and measures for an early return to work after illness. Social partners were involved.
UK	Programme to reduce work related illness. Promoting working after illness or injury. "The new deal 50+". Several recommendations without statutory legal basis.

The European council of Lisbon put as objective to increase women's employment rate. The gender gap has received little attention in national policies reviewed here and the inactivity of women at the advanced ages remains very high compared with the male population.

OECD (2005) proposes the following reforms:

- invest in the system of the young children care (e.g. Denmark). This might also relieve grandparents and consequently increase labour participation of older women;
- apply to the second contributor of income a fiscal treatment identical to that of an (isolated) individual. This ought to favour a system of separate taxation;
- reform the tax system on the part-time in certain countries.

These measures could have an impact on the employment of older women too.

1.3 Working time

1.3.1 National policies

In this section, we will look at existing European policies on part-time for older workers and especially if there are policies on part-time for older workers with health problems.

Belgium⁷⁹

The federal government in Belgium introduced a break scheme in 1985. The basic principle was to enable all employees to take a break or reduce their working hours for a certain period in agreement with their employer. For employees aged 50 and over who have been employed for 20 years or more, a half-time or a one-fifth reduction is possible, with no maximum duration (available up to retirement age). Women, especially, participate in the system. In 2002, 78% of all participants were female. The majority of men take breaks towards the end of their careers, when they are over 50. Although the scheme was meant to encourage a “longer working life”, its evaluation revealed that it might have a negative impact on labour market participation. It may be that people use it as a first step to early retirement rather than as an alternative.

The Flemish Region provides financial incentives in order to incite older workers to continue work part-time. It favours employment for old workers at the end of their career (Landings employment) to enable workers to stay in the labour market but in less physically demanding jobs.

Belgium also creates a Part-time allowance for older unemployed workers. In deed, Belgian authorities consider that part-time work could be an interesting solution for those with health problems or hard working conditions. Helping workers in bad health by adjusting their working time to their working capacity is one of the Belgian solutions to avoid some early retirement.

Denmark

Several of the collective bargaining agreements covered by LO/DA contain barriers and limitations on concluding part-time work agreements directly between employer and employee⁸⁰.

First, the seniors will be covered by senior-relevant provisions or social provisions/chapters in the agreement. Hence, in most agreements, seniors have the possibility to deviate from the contractual employment conditions and, for example, agree upon shorter working hours than those indicated in the agreement. Impediments or limits on collective bargaining agreements for the possibilities of already employed workers to conclude agreements for part-time work directly with the employer have been invalidated.

Germany⁸¹

In Germany, smooth transition to retirement is possible through the old-age part-time employment act. Old-age part-time work contracts can be concluded with persons aged 55 years or older who had been insured against unemployment or sickness benefits for at least three years during the last five and who are not yet entitled to an old-age pension without adjustment. The working time must be reduced by exactly 50% over the entire period of the agreement but the distribution of work during the contract period is completely flexible.

In practice, many collective agreements, especially in some larger sectors (including many industries where the hardship of work often leads to health problems for workers), contain regulations that are more beneficial, thereby encouraging employees to take up old-age part-time work contracts.

We can also notice that in 2000, eligibility of the scheme was extended to older persons working part-time to avoid the indirect discrimination against women that could have resulted from a regulation directed at full-time workers only.

Results show that although companies in some countries (e.g. Germany) are obliged by law to offer their employees adequate part-time jobs on request wherever possible, the managers of quite a large

⁷⁹ Dick Moraal / Gudrun Schönfeld op. cit.

⁸⁰ Seniors and the Labour Market, Danish Employers' Confederation; 2003

⁸¹ Dick Moraal / Gudrun Schönfeld op. cit.

share of establishments regard such a transition as being very difficult, if not impossible. The switch from full-time to part-time hours is particularly difficult in companies that do not have recent experience of part-time work⁸².

Spain

In the 1990s, the government reforms of the labour market in Spain set out to increase the low incidence of part-time work. Consequently, a series of reforms suppressed certain impediments to part-time work. The most recent legislation equalised pension rights of part-timers with those of their full-time counterparts.

Recent legislation has also introduced flexibility in the definition of working hours of part-time workers. Working time flexibility, job rotation and wider possibilities for a second career will be especially beneficial to older workers who want to continue to work but differently because of their abilities.

France

In France, some sectors with hard working conditions and workers in bad health, like steel industry for example, part-time retirement is proposed instead of early retirement.

In general, a phased retirement scheme is possible in France for all workers but under certain conditions. Phased retirement allows workers who are 60 years old or more to work part time and receive, in counter part, part of their state pension. Since 2006, conditions to enter this program have become less strict.

Netherlands

As noted in Part II, Netherlands had the highest number of people with part-time jobs. The following may help to understand the reasons.

In 1982, the “Agreement of Wassenaar” was adopted. “Time” was the key concept in this agreement. Firstly, all workers would get more free time. It was agreed that increases in the cost of living would be compensated partly in money and partly in extra days off per year. Secondly, there would be strong support for ageing workers to leave the labour market early⁸³.

The Equal Treatment (Working Hours) Act (1996) prohibits an employer from discriminating between full-time and part-time employees, unless there is an objective justification for doing so. It is also unlawful to discriminate between part-timers who work more or fewer hours. A part-time worker is proportionally entitled to the same pay, the same bonuses and the same number of days’ holiday.

In February 2000, the Part-time Employment Act was passed, giving employees the right to reduce or increase their working hours, with employers able to deny employee requests for such changes only on the grounds of specific conflicting business interests. The Part-time Employment Act is part of the framework Work and Care Act, which brings together numerous existing and new leave provisions (such as time off to care for family members) aimed at helping reconcile employment and family care responsibilities. This legislation responds to a trend that was already set in a considerable number of collective agreements. In 1999, two thirds of the collective agreements in the Netherlands contained provisions on the adjustment of working hours for individuals⁸⁴.

⁸² Riedmann A., (2006)

⁸³ Dick Moraal / Gudrun Schönfeld op. cit.

⁸⁴ Portegijs et al, (2002)

In 2004, the life-span leave (LSL) scheme was introduced. It is based on the personal savings of each participant. The scheme includes options to take part-time or full-time leave in all stages of a career.

Austria⁸⁵

Closely related to the abolition of early retirement schemes, the Austrian old-age part-time work scheme became a de facto alternative to early retirement. Employees could reduce working time while gross pay is not reduced proportionately. But it is compulsory to hire an additional employee as a replacement for the person in the old-age part time scheme.

By diverse policies Austria wants to find a balance between work and private life in the organisation of working time. Human resource management of each company is advised on what basis and how to go about organising the work rhythm of older workers.

Finland

Working Hours Act (1996; amended 2004) permits reduced work hours based on fatigue and the reduction of work efficiency caused by ageing, for example. The employer and employee can make an agreement for a maximum of 26 weeks with the possibility to continue the arrangement when work hours are reduced.

Finland has a part-time pension scheme. People above 56 years old can choose to work part-time and be compensated for their loss in income.

The part-time pension in Finland is an increasing popular way to achieve a smooth transition from work to retirement.

Sweden

In Sweden, the government has established an 11 point programme for better health in working life which includes measures for a better working environment and working time organisation.

In 1999, Sweden introduced a new public old-age pension system. Sweden wants to bring more flexibility into the old age pension system. From the age of 61 onwards it is possible to work and draw a pension at the same time.

The Swedish Agency for Government Employers believes that the system could help to retain older workers longer and secure a smooth transition of knowledge between generations.

United Kingdom

The “New Deal 50 plus” programme favours flexibility in working time through skills improvement for people aged 50 or more.

1.3.2 Comparative analysis

Phased retirement and part-time work for older workers is one of the important topics of ageing policies in European countries. All European countries have part-time programs for older workers but only a few insist on older workers with health problems, notably Nordic countries.

In Denmark, collective agreements have special clauses concerning part-time employment of older workers. Agreements between workers and employers are also promoted in Belgium, while in France and Germany, certain industrial sectors provide for part-time work for older workers.

⁸⁵Walterskirchen, Ewald (2006)

Suppression of impediments to part time work has been favoured in Spain and the Netherlands; similarly in Italy, a new law gives protection to part-time workers and encouraging part time work.

The Netherlands have a long history of promoting and protecting part-time employment.

The balance between 1) work and private life (Austria) or 2) work and care (Netherlands) is an important dimension for time budgets constrained by bad health.

An obstacle to part-time work might be low resources. Austria, The Netherlands and Finland compensate income losses due to reduced work hours. Several countries (notably Poland and Sweden) make it possible to draw at the same time a pension and income from work.

Table III.2: Summary of key national instruments / policies

<i>Country</i>	<i>Instrument / Policy</i>
BE	Enable all employees (50+) take a break or reduce their working hours for a certain period in agreement with their employer.
DK	Part-time work of older workers is regulated by special chapters in collective agreements.
DE	Old-age part-time employment act. Some specific sectors contain regulations for part-time work of older workers but employers are reluctant.
ES	Suppression of impediments to part-time work for older workers.
FR	Part-time schemes or phased retirement for some sector with hard working conditions.
NL	The Equal treatment act (same rights). Part-time Employment Act (takes into account care). Life-span leave scheme (personal savings). Elderly employees can reduce their working time.
AT	Employees could reduce working time while gross pay is not reduced proportionately.
FI	Possibility to reduce working time based on fatigue and the reduction of work efficiency caused by ageing. Compensation for income loss.
SE	Measures for better working time organization in the program for better health in working life. From the age of 61 onwards it is possible to work and draw a pension at the same time.
UK	Flexibility in working time through skills improvement (with the “New deal 50 plus”).

The development of part-time work among older workers might be slowed down by employees or employers. One of the reasons given by employees for not switching from a full-time to a part-time job is the fear of suffering disadvantages at the workplace, particularly fewer career prospects. Also, its impact on old-age pension is not always clearly defined.

1.4 Conclusions

The review of national policies and programmes has identified promising initiatives, notably in the following areas:

- senior policy (centring on less physically demanding tasks and shorter working hours),
- disability and activity limitations management,
- retention of workers with health problems (health prevention),
- re-integration of workers after a long absence,
- working conditions and ergonomic aspects,
- sensitisation of employers and trade unions,
- work environment (requirements),
- incentives to continue working with better working environment,
- rehabilitation,
- improving the disability pension schemes,
- global health approach,
- improvements in working conditions.

Nordic countries and in particular Denmark, Finland and Sweden have invested in health management of older workers through many programs and policies. Also, they promote a consensual approach between all involved parties.

The adaptation of working time (part-time work) plays an important role, notably:

- Phased retirement and part-time work for older workers, notably for older workers with health problems,
- collective agreements concerning part-time employment of older workers,
- suppression of impediments to part time work,
- protecting social rights of part-time workers,
- compensation of income losses due to reduced work hours,
- possibility to draw at the same time a pension and income from part time work.

National policies aiming to guarantee equal rights with full time workers and compensation for income losses might help maintain people with chronic health problems on the labour market.

III.2. Financial (dis) incentives

2.1 Introduction

Differences in the health status of populations may not explain by itself the different employment rates across Europe. The employment rates of seniors are also influenced by institutional differences (pay-as-you-go system, early retirement schemes, disability pensions...) and the national labour market specificities (management of careers ends into companies, economic growth, adult learning, etc.). Differences in managing the end of work life, moving from work into retirement (approaches to accessing early retirement and weak incentives for pursuing professional activity), and deterioration in health status seem to be important factors.

If the legal age of retirement is tending towards 65 across Europe, differences remain in the age at which people stop working. This was 61 on average across the 25 Member States in 2004.

In the following, we will focus on earning tests, sickness and disability benefits.

2.2 Earnings tests

One finds earnings tests in a number of countries, some of them with a flat rate benefit system such as Ireland and some of them with an earnings related system such as Belgium.

The following table gives earnings tests in a number of EU countries.

Table III.3: Earnings tests in EU countries

	Threshold (% of average earnings)	Withdraw rate (%)
Deferral not possible		
Australia	8	50
Austria	30	Full
Belgium	33	100
Denmark	50	60
Greece	116	Full
Ireland	None	Full
Norway	18	50
Portugal	None	Full
Spain	None	Full
Deferral possible		
Italy	23	100
No restrictions		
France	-	-
Finland	-	-
Germany	-	-
Netherlands	-	-
Sweden	-	-
Switzerland	-	-
UK	-	-

In some countries workers are allowed to defer receipts of benefits and thus gain additional pension entitlements. Note that even when there are no earnings tests income taxes and even payroll taxes are applied to both earnings and pension benefits.

The preceding table has to be interpreted with caution. First, this is an evolving matter and it does not include recent reforms that abolish or weaken earnings tests. Second, the Table gives average values that tend to conceal a complex and diverse reality. To take the example of Belgium, there are 12 thresholds that range from 5 937 to 18 553 € and depend on three factors: whether or not the worker has dependent children, whether or not he or she has less than the "legal" age of retirement (65), whether he or she benefits from a retirement or a survival pension. The next table provides those different threshold values.

Table III.4: Threshold values in Belgium (in euros for 2005)

	With dependent children	Without dependent children
Self-employed		
- retirement benefits before 65	8 905	5 937
- survival benefits before 65	14 843	11 874
- survival and retirement benefits after 65	13 813	10 845
Salaried		
- retirement benefits before 65	11 132	7 421
- survival benefits before 65	18 553	19 843
- survival and retirement benefits after 65	17 267	13 556

For rather obvious reasons, there is no economic objection to have earnings tests when the pension system is not contributory and thus plays the same role as any welfare program. When the pension system is contributory and when the effective age of retirement is particularly low, which is the case of Belgium, and then one hardly finds any good rationale for earnings tests. Empirical evidence suggests that the abolition of earnings tests have a small but significant impact on labour supply.

Earnings test and implicit taxation on prolonged activity are both ways of discouraging elderly workers from remaining active. Earnings tests concern workers who benefit from some types of benefits and would like to supplement these benefits by working and earning some income. They do concern workers before formal retirement (disability, unemployment, early retirement) and after formal retirement (public pensions).

Implicit taxation is based on the existence of social protection schemes that allow workers to get social benefits before the statutory age of retirement upon the condition that they stop working. These schemes have to be reformed but with caution. Take just one example. Let us assume a reform such that unemployment insurance or disability insurance is not subject to any earning test. This reform would clearly depress the rate of activity of the elderly workers and endanger the financial viability of social protection.

In the following, we will analyse the possibility for accumulation of different benefits (notably disability pensions) in the Member States and will identify the Member States which have adopted innovative measures to abolish financial disincentives for older workers.

2.3 Sickness and disability benefits

2.3.1 National policies

One important way to increase employer's demand for older workers is to reduce the cost of hiring older people with fragile health. The most common proposal is to eliminate employers' expenses related to health for those 65 and over. This would relieve companies of a substantial expense.

Generally, the cost for the employer might be the amount of salary for the first days of absence or the insurance cost. There is a high variety of situations in the Member States.

It is important to note that generally, a sick person after a certain period of time may receive a temporary disability benefit and if the situation is permanent, he might gain a disability pension. Generally, the employers are financially responsible for the short-term absences while the economic burden of long-term absence passes over to the public insurance system.

In the Netherlands, recent measures include removing the obligation on employers to pay disability insurance for employees older than 55 a threshold which is further lowered to 50 years when recruiting new personnel.

In Finland, employers pay full salary for the first 9 days if the employment relationship has lasted at least one month. If the employment relationship is under one month, he pays 50 % of the salary. By collective agreements most employers pay full salary during the first 1-2 months.

The Finnish case presents an interesting specificity. The system takes into account seniority. Hiring of older persons is not costlier compared to younger healthy candidates.

Disability benefits are generally granted to persons with work incapacity. The candidate must meet a threshold of work incapacity and a certain number of other conditions. The threshold varies across countries but in the majority of cases it is between 33% and 50% of work reduction.

The disability benefit may be the result of insurance or a non-contributory social assistance benefit. The question is whether the beneficiary may accept a job and what are the implications for the granting of the benefit. In fact, the argument is that if the beneficiary accepts a job he may lose his benefit. In this case, it is not sure that he will recover his pension if he is not successful with his new job. Consequently, he will be discouraged to undertake a job search.

Consequently, a solution might be the possibility to accumulate an incapacity pension and earnings from work. As noted before, earnings tests are generally required for non-contributory benefits. Accumulation seems more acceptable in case of contributory pensions compared to social assistance benefits.

Another important point concerns the possibility of early retirement for health reasons. Recent reforms to abolish such schemes may push people with disability towards disability pension schemes.

We present below the possibilities to cumulate invalidity pensions with earnings from work⁸⁶. We may notice that there are important differences across Member States.

Belgium

A professional activity during the period of disability may be authorised by the mutual insurance company's medical advisor. The amount of the daily benefit thus allocated may not exceed the daily amount that would be allocated if there were no accumulation.

⁸⁶ MISSOC

Denmark

In Denmark, the financial amount of disability benefit (early retirement pension) is high. Recent measures have tried to limit the economic attraction of these pensions⁸⁷. The Danish scheme includes people with social problems. In the present legislation and practice a person's lack of vocational ability (earning ability) is the basis for decisions on awarding the disability pension. In the future the focus will be on the persons' "working ability", i.e. on the potentials of the persons rather than "non-abilities".

The granting of the disability pension is subject to means test since 2003. This is a specificity since the big majority of Member States do not require a means test for contributory invalidity pensions.

Accumulation is possible, but with benefit reduction. Certain specific parts of a pension depend on the earnings of the pensioner.

No retirement is possible before the statutory pensionable age of 65 years.

Germany

Germany focuses on rehabilitation. Benefits for medical rehabilitation and participation in the labour market (e.g. occupational training) are favoured measures. The pension insurance must examine whether a pension claim may be avoided by rehabilitation measures.

Pension is reduced if earnings exceed fixed additional earnings ceilings. The payment of pension is suspended if earnings exceed the upper ceiling. In certain cases, a gainful occupation - irrespective of earnings - can affect the continuation of the pension entitlement.

Spain

Permanent incapacity pensions are compatible with earnings, provided the activity is consistent with the pensioner's physical condition and does not imply a change in his/her capacity to work for revision purposes.

France

General scheme for employees : Suspension of the pension if the pension and the salary received during two consecutive quarters are greater than the average quarterly salary for the last calendar year before stopping work prior to invalidity.

France has extensively used early retirement in the past.

The Netherlands

Employers and trade unions have cooperated in the past in order to use invalidity benefits as an early retirement. In fact, the disability-program became a very popular arrangement, which employers could use to shed elderly, less productive, employees. So, often, as part of a so-called social plan – in which the employer and the trade union agreed on the kind of support the firm would offer to those leaving the company – it was often (tacitly) agreed that those over 55 would be offered the option of entering the occupational disability scheme. Also, the disability benefits were more generous than unemployment benefits. As a result of this, both employers and employees had a preference for the

⁸⁷ Dick Moraal / Gudrun Schönfeld: Main features of age-oriented policies in Austria, Belgium, Denmark, Germany and the Netherlands; (Synthesis report) (Leonardo II project Ageing and Qualification: "Betriebliche Weiterbildung von älteren Arbeitnehmerinnen und Arbeitnehmern in KMU und Entwicklung von regionalen Supportstrukturen" – <http://www.bibb.de/en/19230.htm>), Bonn 2006

disability route to unemployment⁸⁸. Latter, the Dutch government limited eligibility for invalidity benefits by tightening entry conditions and reducing benefit levels.

Generally, if a beneficiary finds suitable employment the disablement category in which she/he has been classed may change, depending on what he/she earns doing this work. This means that the rate of benefit may be revised.

The Work Handicapped Reintegration Act (REA) has several interesting financial incentives. Any employer who employs a disabled worker or who assigns him to a more suitable position within his company can receive a considerable compensation to finance all costs this may involve. It is under this Act also possible to grant disabled worker facilities which tend to maintain, restore or improve his incapacity for work.

There is no early pension scheme.

Austria

Regulation allowing taking into account those persons entitled to an invalidity (disability) pension and receiving an activity income superior to the limit of € 341.16, under which activity is not subject to social insurance.

In this case, the partial pension due is calculated by deducting a certain amount from the full rate pension, fixed in accordance with the different parts of the global income (activity income + pension). Up to a global income of € 973.63, the disability pension is entirely paid.

Rehabilitation takes priority over the pension. Before the invalidity pension is approved, an attempt should be made to reconstitute the patient's ability to work through rehabilitation.

Poland

The pension is suspended or reduced if the beneficiary exercises a professional activity and earns more than the following thresholds:

Earnings below 70% of the national average wage: no effect on pension; earnings between 70% and 130% of the national average wage: basic amount of the pension reduced by 24% or by 18% in case of Partial Invalidity Pension; earnings over 130% of the national average wage: pension suspended.

Rehabilitation usually starts after exhaustion of sickness cash allowance, but can also take place within six months after the onset of invalidity. This practice may lengthen the time span out of work and constitute a disincentive for re-entering the old job or staying active on the labour market.

Finland

National pension: If the pensioner takes up work similar to his former activity, he is no longer considered as disabled and the pension is withdrawn. The pension can be suspended for 6 - 60 months if the pensioner finds employment. In the case of individual early retirement pension, same rules apply as for the earnings-related pension,

Statutory earnings-related pension: Within certain limits, the pensioner is allowed to work while receiving the pension. In the case of disability pension, if earnings are 40% but not 60% of the pensionable salary, the full disability pension is changed to a Partial disability pension. If earnings exceed 60% of the pensionable salary, the pension is withdrawn.

A tax deduction based on the degree of disability is allocated to a large number of people. This might be an important incentive to search for work. Due to low income most severely disabled persons

⁸⁸ Arie Kapteyn and Klaas de Vos: Simulation of Pension Reforms in The Netherlands; Tilburg/Santa Monica, February 2004

cannot benefit from the tax deduction based on the degree of disability at all or they benefit only partially. The tax deduction based on degree of disability is meant for persons who have a permanent disability arising from an illness, impairment or disability. It is a tax deduction on earned income, and the degree of disability must be at least 30%.

Finland focuses on preventing disability. A rehabilitation allowance is payable after a short waiting period of a few days. Also, before making the disability pension determination, the pension provider has to make sure that the applicant's prospects of rehabilitation have been investigated. Vocational rehabilitation became a statutory earnings-related pension benefit from the beginning of 2004.

Slovenia

Right to part-time work and Partial Invalidity Pension: An insured person afflicted with invalidity is, if he is no longer capable of working full-time or without occupational rehabilitation entitled to part-time work and partial invalidity pension.

Partial invalidity pension is assessed in the percentage, corresponding to the shortening of full working time, from invalidity pension the insured person would be entitled to on the day of occurrence of invalidity.

There is no special early pension.

Sweden

Employers and trade unions have cooperated in the past in order to use invalidity benefits as an early retirement. Sweden made the retirement through invalidity benefits less attractive. However, long-term sickness compensation remains relatively high, in Sweden.

Accumulation is possible for Assistance Allowance, Car allowance, Care Allowance for Disabled Child and Disability Allowance.

Sickness compensation may be granted to people who for medical reasons have a working capacity reduced by at least 25% for a period of at least one year. If the person receives sickness or activity compensation, he/she has the possibility to work without losing entitlement to compensation. This is called dormant sickness/activity compensation.

When sickness/activity compensation is paid for at least a year and the person wants to try to see whether he/she can cope with working, the person can apply for a trial period in which he/she receives compensation and pay at the same time. If the trial is successful, the person can apply to have his/her compensation made dormant.

The trial period and the period of dormant compensation may together last for up to 24 months or for the remaining period for which the person has been granted compensation.

There is no early pension.

United Kingdom

Accumulation of disability with earnings under permitted work rules is possible up to a maximum amount.

In the United Kingdom, the government has modified the social security rules for disabled people on long-term incapacity benefits. The purpose of the reform was to make it easier for them to take up employment by guaranteeing that if their job does not work out because of their illness or disability, they will be able to return to their previous level of benefit up to a year later. In April 1999 further changes were made to the benefit rules to help people with disabilities back to work. They include

allowing those on incapacity benefits to earn a small amount of money and to take trial periods in jobs without losing the benefit.

An interesting incentive to work is the Working Tax Credit (WTC). People who are employed or self-employed who usually work more than 16 hours/week, are paid for that work and expect to work for at least 4 weeks benefit from a Working Tax Credit.

One of the qualifiers for the credit is that the beneficiary already receives a benefit related to a disability. It is restricted to those in employment for more than 16 hours/week. The amount of tax credit received depends on annual income and the number of dependent children.

There is no early State Pension.

2.3.2 Comparative analysis

The following table summarizes the national situations.

Concerning sickness leave, there are no big differences except the Dutch and Finish specificities noted above.

Concerning disability pensions and work earnings accumulation is possible in several countries.

Table III.5: Sickness benefits and Invalidity pensions

	Summary of maximum number of sickness leave paid by the employer *	Invalidity pensions and accumulation with earnings from work
BE	30 days (degressive contribution in certain cases)	May be authorised. Maximum benefit
DK	No statutory continuation (unless agreed)	Accumulation possible. Benefit reduction. Focus on working ability. No early retirement
DE	6 weeks	Pension is suspended if earnings exceed an upper ceiling. Focus on rehabilitation
ES	From the 4th up to the 15th day	Accumulation possible if compatible with health
FR	Entire (or a part) difference between the salary and the amount of the sickness cash benefits	Pension is suspended if earnings exceed an upper ceiling
NL	70% of wages for 104 weeks	The rate of benefit may be revised. Work Handicapped Reintegration Act No early retirement
AT	Between 6 and 12 weeks. Reduced rate for an additional 4 weeks	Accumulation up to a ceiling Focus on rehabilitation
PL	33 calendar days	Pension is suspended if earnings exceed an upper ceiling. Rehabilitation may be delayed
FI	9 days	Pension is withdrawn if earnings exceed an upper ceiling. Tax credits. Focus on prevention and rehabilitation
SI	30 calendar days	Accumulation possible No early retirement
SE	From the 2nd up to the 14th day	Accumulation possible – Dormant pension No early pension
UK	4 consecutive days up to a maximum of 28 weeks.	Accumulation possible up to a limit Working Tax Credit. No early retirement

* Employers may transfer the cost to the sickness insurance; also after a specified period the worker may claim a temporary/permanent incapacity pension. The cost is transferred to the social security system.

Note: Absence due to an occupational accidents or diseases may be governed by specific rules. Also, the employer may transfer the cost to his insurance.

Source: MISSOC

Sweden (and in a lesser extend Finland) allow disability pensions to remain dormant during periods of employment to help people with disabilities enter the labour market.

The UK and Finland have granted work credits to employed disabled. This is a way to decrease the implicit tax rate on work and favour labour participation of older workers.

However, we observe that in certain countries accepting a job is a very risky initiative. The loss of disability benefits might be a serious obstacle to an active job search. It is consequently desirable to eradicate extreme cases and allow full accumulation at least for a minimum period. Also, in case of loss of the job, the beneficiary ought to recover his pension without undertaking a new long process of administrative recognition.

Denmark, Netherlands, Slovenia, Sweden and UK have no early pension schemes. Recent policies to early retirement schemes may increase the number of people asking for a non-contributory allowance (or minimum resource guarantee).

Recent, reforms in Denmark, Netherlands and Sweden aim to reduce disability pensions.

Despite several national reforms to reduce disability pensions, the evolution of the number of beneficiaries increased in certain Member States. We may note a sharp increase of contributory disability pensions (more than 20% between 2000 and 2005) in Austria, France and Sweden. Significant decreases (more than 10%) took place in Germany and Slovenia which can hardly be attributed to the changing ageing structure of the population⁸⁹.

High replacement rates and flexible conditions of eligibility have played a role in making disability the main means for achieving early exit from the labour market in the Netherlands and Sweden. Other countries such as France or Germany favoured premature exits from the labour market by unemployment schemes (for example job seeking exemptions in France) in the past, but have attenuated their policies recently.

In France, the reduction of early retirement schemes might be the reason for the continuous increase of invalidity pensions.

In the Netherlands (and in Hungary), disability benefits have often been used to finance premature labour market withdrawal and as a substitute for unemployment insurance.

In comparison, the number of pensions for work accidents and occupational diseases is generally stable or decreasing (notably in Sweden) reflecting an improvement of working conditions and a change of the industrial structure. But it continues to increase in certain Mediterranean countries.

With the reduction of possibilities for early retirement, invalidity benefit might become one of the main reasons for early retirement in certain Member States.

Critics claim that many individuals can not work longer. Recent policies (elimination of early retirement and rising earliest eligibility age) could impoverish these groups as well as strain social programs like disability benefits. They contend that withholding benefits until a later age hurts those with shorter life expectancies, and shifts more retirement wealth to those with longer lives. These people tend to be low skilled males. Any increase ought to take into account work penibility and life expectancy.

⁸⁹ Data reported in Statistical Yearbooks published by National Statistics Institutes.

2.4 Conclusions

National policies aiming to increase labour participation of older people with health problems include notably:

- reduce the cost of hiring older people with fragile health through removing the obligation on employers to pay disability insurance for older employees
- enable accumulation of disability and earnings benefits without the possibility to recover disability rights if work is not successful
- work tax credits to decrease the implicit taxation rate of work effort
- disability policy ought to be distinguished from other policies (notably early retirement)

Policies to maintain people with health problems on the labour market ought to avoid a further deterioration of their health, notably for certain disadvantaged groups of older workers.

III.3. Active ageing

3.1 Introduction

Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance.

Volunteering can be one important element for active ageing. As noted above, several Member States promote volunteering in their health promotion programmes.

In the following, we will first present policies for active and healthy ageing. In a second step, we will focus on volunteering.

3.2 Activity and health

3.2.1 National policies

A large variety of policies and programs are undertaken across countries in order to promote active and healthy ageing.

Belgium

In Belgium, active and healthy ageing programs are developed at the Regional level.

Belgian's Regions also insist on the importance of physical activity (and in particular walking) and on avoiding medication excess for seniors. Information campaigns are spread into Medias.

Germany

Germany promotes Post-retirement Activities (lifelong learning, voluntary activities, and leisure groups). It aims at giving the elderly opportunities for integration in the society and for productive post-retirement activities. There is no central organisation co-ordinating this field, but rather a multitude of initiatives, some carried out by the public sector with the aid of senior citizen associations and some by individual associations or even firms.

The German Ministry of Health and Social Security funded notably a research project on "Rehabilitation in nursing homes" carried out by the Friedrich-Alexander-University. Cognitive activation promotes perception, attention and concentration, absorption of information and processing performance of the short-term and long-term memory. The results demonstrate that rehabilitative measures work also for cognitively and functionally disabled people. In the long run, the inhabitants kept their autonomy longer. Elements of the cognitive training have been used in and transferred to several projects and settings in Germany and Austria.

Spain

The Action plan for older persons 2003–2007 aims at improving the conditions of life for older people and putting a wide net of resources at their disposal. The aim is to improve the life conditions of older people by providing them with a wide range of resources. The plan has four action areas, equality of opportunity, cooperation, training and information and investigation.

In Spain, each Region has to create active ageing program. A good practice example is the senior centre in Asturias. The social centers for seniors are gerontology facilities opened to the community that promote active ageing, facilitating personal development, the coexistence and social participation.

In those centers, the elderly can develop participation skills and can join voluntary programs and generation interchange programs. All these programs keep the elderly active in their region. To join this program they have to contact the Municipal Centre of Social Services located in the zone where the participant resides.

France

In France, healthy and active ageing project partners are the National Nutrition and Health Programme, the National Institute for Prevention and Health Education and the National Office Solidarity Autonomy.

France has developed information campaign through TV programs on “Healthy Ageing” and improvement of the old people’s social representation through information campaigns. This is important because it can touch every senior, even those without social interactions or the poorest ones. France works at maintaining the social link and favouring the experiences from intergeneration housing. France also realized programs on the drug prescription of the elderly, in order to avoid excess medication that would impeded on their social life.

Campaigns and programs for active ageing launched in France covered ‘national plan for health education’(2001), ‘national plan for health nutrition’ (2001), ‘keys for well-ageing: prevention of falls in older people’ (2001), ‘prevention and care organization program for fragile elderly people (2002-2005)’, ‘national program for the reduction of cardiovascular risks 2002-2005’ (2002-2005), cancer plan 2003-2007’ and ‘plan for health at work 2005-2009’.

The Netherlands

Long-term policy stimulates participation and healthy lifestyles. The government considers that factors such as obesity and lack of physical activity are well on their way to displacing smoking as the major health problem. The government favours sport and physical activity and is committed to combating lack of exercise.

Furthermore, it considers that the labour participation rate amongst older people ought to be increased, age discrimination ought to be eliminated, possible obstacles to anyone wishing to work after 65 ought to be removed and there should be incentives for doing volunteer work.

The Dutch government has decided to reform the healthcare and welfare systems. From 2006 onwards, local government will provide support and facilities for the elderly and for the disabled where liveability, participation and mobility are concerned. Citizens will have more individual responsibility. This will manifest itself in the possibility to exercise one’s greater ability to live independently, and in informal peer support groups.

The Ministry of Health, Welfare and Sport supports more and more activities related to sport and physical activity developed and tailored to meet the specific wishes and capabilities of the different groups of old people.

Austria

In Austria, prevention in old age is now given more attention by geriatrics. Strategies focus on raising awareness about early-diagnosis tests, preventive vaccinations as well as changing daily life organization given that the number of home accidents increases with age. According to the results of a micro-census survey from 1998, 29 per cent of persons over 60 years of age are in need of assistance

with regard to shopping and household activities (cooking, washing etc.); a further seven per cent are in need of more professionalized care as a result of chronic disease impairing daily activities. In absolute numbers this is equivalent to just over 550,000 persons.¹¹ In the same year, the number of persons receiving allowance for nursing care (Pflegegeld) was 315,000, of whom 89 per cent above 60 years of age. This shows that the number of persons who are in need of care is far greater than those receiving nursing allowance. This is due to the fact that eligibility for nursing allowance is restricted to those whose need is estimated to relate to at least 50 hours / week.

The Austrian law on Health promotion, Education and Information focuses on health promotion of specific populations such as the elderly and the chronically ill. Mental (psychosocial) health is also mentioned.

A campaign on healthy lifestyles was initiated, called “It is never too late to take the first step”. The themes covered included exercise, mental health, “looking after yourself” and nutrition. The goal was to raise health awareness among the general population.

In addition, the campaign on “Prevention for healthy ageing” focussed on Nutrition, Physical activity, Tobacco, Alcohol and Tying health promotion to the educational system.

In Austria there are several regional initiatives in which the different provinces play a large role. A good practice coming from Austria is the “Empowerment Plan 60” aiming at greater participation and empowerment of older people through community-based interventions.

Poland

The Law on Public Benefit Activity and Volunteerism of April, 2003, makes public administration organs responsible for implementation public tasks in cooperation with NGOs and other institutions at local level. According to Article 5.3, local governments are obliged to prepare an annual programme of cooperation with aforementioned institutions.

The objectives of cooperation programmes are:

- Improvement in fitness and life activity of elderly persons,
- Helping them to integrate socially and maintain social contacts,
- Development of diverse forms of long-term and hospice care and supporting care-takers for the chronically ill and/or disabled elderly persons,
- Reducing isolation, marginalization and social exclusion of seniors and combating use of violence against the eldest generation

Planned activities include health prevention, physical exercises, organization of meetings and integration events, supporting individual and group assistance to the elderly, and help in creation and management of daily support centres, and 24h care for the elderly;

The expected results include raising the standard of living of the elderly, improvement in quality of the services, enabling elderly people to solve some of their problems by means of self-organization and mutual aid, improvement in life activities and development of the interests of the old generation,

As the range of programs is at discretion of local governments, it's hard to say how many of them and to what degree recognized the importance of ageing society problems.

The issues and matters related to the Aged are mainly in the hands or in the field of interest of the Department of Social Assistance under which there are different kind of Centres of Social Assistance.

It is also important to note that the NGOs played at least an equal role in helping active ageing as formal organisations. For example, there is relatively a lot of Senior Clubs (or so-called Golden Age Clubs - such clubs were established under communism. The Clubs are organised by different

institutions: the culture centres, houses of culture at neighbourhood, flat co-ops, NGOS, but quite often the Polish Association of the Pensioners and Retirees.

There are quite a lot of different kinds of small programmes and initiatives for old persons, which are organised by mainly non-governmental organisations.

The National Health Programme (2006-2015) aims at reducing social and regional differences. It pays special attention to mother-and-child protection, young adults and older and disabled people. The three main directions are: a) to reduce differences in access to health services, b) to support healthy lifestyle choices, and c) to create a healthy environment.

Finland

Finland's policy on ageing has been mostly government and municipal policy, with a clear emphasis on social welfare and health policy.

Finland focuses on health-enhancing physical activity for older people. The "Health 2015" programme promotes health promotion. It notes that⁹⁰:

- ageing people must be ensured opportunities to function actively in society, to develop their knowledge and skills and their ability to care for themselves,
- ageing people should have the possibility to live an independent life of good quality with an adequate income,
- residential and local services and transport must safeguard an independent life even when ageing people's capabilities deteriorate, and
- It should involve municipalities, informal care-givers, voluntary organisations and commercial services.

The National Ageing Programme (1998 – 2002) included a reform package of working life structures and legislation as well as various survey, training and experiment projects. The programme gave rise to an active debate on the issue of ageing and was followed by three extension programmes (TYKES: Work Place Development Programme, VETO: well-being at work and extending working life, NOSTE: education and training of adult population).

The Finish's national strategy and policy on ageing plan contains five inter-connecting segments, based on the segments defined by the UN, which have been modified and combined so that they represent the Finnish ageing policy. The segments are: working life, livelihood, housing and living environment, social and health services and participation. Connected to each segment the plan presents future vision, targets, strategies and the plan of actual actions. It also presents responsible stakeholders and the timetable for each action.

Sweden

The National Institute of Public Health where commissioned by the Government to plan for a physical activity year 2001 in collaboration with a number of government agencies and organisations. In an effort to promote healthy lifestyles, Sweden has launched the "Sweden on the move 2001" campaign. The national programme placed in the forefront the benefits of physical activity for better health and well-being, and its efficiency in preventing disease. The message was built around the importance of daily physical activity to promote good health, and that 30 minutes of daily physical activity can have a positive preventive effect on health.

The aims and objectives were based on the Ottawa charter and the five strategies:

- Strengthen community action;

⁹⁰ Healthy Ageing: EU funded projects 2004-2007; <http://www.healthyageing.nu/>

- Develop personal skills;
- Reorient health services,
- Create supportive environments; and
- Build healthy public policy, and on the National Public Health Committee's proposals for aims for physical activity.

Although elderly people were not specifically highlighted as a target group in the objectives of the campaign, they benefited from it and acquired healthy habits through increased physical activity. The activity was initiated locally in the country's municipalities and regions.

United-Kingdom

The UK National Service Framework for Older People (NSF), together with the local NHS and the voluntary sector are developing and implementing plans for healthy communities. A national programme led by the Primary Care Development Team has shown the value of engaging whole communities in an effort, helping to reduce falls and their consequences by increasing opportunities for exercise and balance activities. Their goal is also to improve home safety for older people. To achieve it they decided to increase awareness of home safety and to improve the home environment. The Partnership will provide leadership in local community, in raising awareness, promotion and use of supports, challenging stigmas & barriers to health, promoting healthy lifestyles. Through volunteering, participation activities, health improvement initiatives and partnership working using community development approach. The community approach makes policies closer the elderly and will certainly be more efficient than national uniform plans.

The British Department of Health commissioned "several projects aiming at promoting regular physical activity and independence for older people. Several active ageing programs focussed on physical activity, fight against discrimination and social participation.

3.2.2 Comparative analysis

Several European countries have developed active ageing policies during the last years. They aim to help older people to stay mentally and physically healthy.

The UK, Finland, Sweden, the Netherlands and Austria focus on promoting physical activity of seniors⁹¹. Other activities include voluntary activities (notably Germany, Netherlands and United Kingdom), and training and education of elderly (notably Germany, Spain, France and Finland).

Campaigns on healthy lifestyles promote exercise, mental health, nutrition, physical activity, tobacco, alcohol and education (e.g. Austria). Health prevention and healthy lifestyles are part of several national programmes (notably Netherlands, Poland, Sweden and Finland). Healthy lifestyles in France focus on nutrition.

Social contacts are promoted notably by Belgium and Spain through the creation of local centres.

Cognitive activation has been promoted notably by Germany.

A good example in Finland concerns the organisation of ageing policies. Ageing policies are implemented through a cooperative national approach composed by different ministries and institutions like labour ministry, health ministry, education ministry and social security institutions that could deal with different aspects of ageing. Like this, ageing policies are taken knowing their impact on vary aspects of older people's life and policies are more efficient.

⁹¹ We may note here the actions of the EU Platform for action on diet, physical activity and health which has brought together key players from industry, NGOs, associations and consumer groups.

Reducing social inequality in health has been stressed notably in Denmark⁹² and Poland.

Table III.6: Summary of key national instruments / policies

<i>Country</i>	<i>Instruments/ Policy</i>
BE	Medication excess prevention and promotion of physical activity among seniors. Prevention of accidents.
DE	Promoting Post-retirement Activities (lifelong learning, voluntary activities, and leisure groups). Independent living.
ES	Each Region has to create active ageing program focused on their elderly. Example: “the senior centre”. Promotes training and information.
FR	Healthy and active ageing: Information campaigns transmit advice to seniors. Reducing health related inequalities.
NL	Promotion of sport, physical activity and volunteering for the elderly. Reducing health related inequalities.
AT	Initiatives for active ageing. “Prevention for healthy ageing” and “the Empowerment Plan 60”
PL	Promotes healthy lifestyles.
FI	Promotion of working life, social and health services and participation. Promotion of physical activity and skills. Healthy ageing. Independent living.
SE	Healthy lifestyles and active ageing. The campaign “Sweden on the move 2001” promoted notably physical activity. Reducing health related inequalities.
UK	Independent living and plans for healthy communities. Reducing health related inequalities. Prevention of falls.

National policies promoting healthy ageing have also focussed on:

- Nutrition: WHO considers that the burden of disease attributable to nutrition is greater than is often thought. A better diet would significantly reduce the risk of chronic disease like cardiovascular disease, cancer, diabetes, obesity, osteoporosis, etc; Programmes aiming cardiovascular diseases and obesity often include a nutrition sensitisation (e.g. Austria, Finland).
- Smoking: Smoking seems to be the most important modifiable risk factor both for young and elderly people. It is also, a major preventable cause of premature death. The Swedish National Institute of Public Health considers that smoking remains the principal cause of death and morbidity in the European Union. We may note the activities of the UK NHS Stop Smoking Services.
- Prevention of cancer: Several countries organise nation-wide systematic breast cancer screening campaigns. Secondary prevention of cancer appears as the most cost-effective alternative. The cost of diagnosis, treatment and follow-up at an early stage of the cancer was estimated to be significant. Several studies in Sweden and The Netherlands have looked into the effectiveness of a screening programme and concluded that one in three deaths from breast cancer can be prevented if women are screened. We may also note the success of the breast cancer screening programmes in Austria and Belgium.
- Cardiovascular diseases are the leading cause of burden of disease in Europe and the main factor for years of life lost due to premature death. We may note the Finnish North Karelia project and the Belgian Heart Disease Prevention Project.

⁹² “Healthy throughout Life” (2002-2010) aims at increasing life expectancy, improving quality of life and reducing social inequality in health. It assumes that the quality of life of many people can be improved substantially by more systematic efforts in counseling, supporting and rehabilitating patients.

- Obesity: The increasing prevalence of overweight and obesity has become a major public health problem in developed countries. Obesity reduces life expectancy and people who are obese or overweight have a higher risk of disease including cancer, coronary heart disease, diabetes and hypertension. According to current knowledge, obesity is a reversible condition, and with careful attention to both prevention and treatment it should be possible to tackle this problem in the future. It has been estimated that, in Europe, obesity, overweight and the treatment of obesity-related diseases account for 2–8% of all medical costs. Available results indicate that life expectancy might decrease due to obesity in the coming years. We may note the Programme for the Prevention of Type 2 Diabetes in Finland 2003-2010 including preventing obesity.
- Falls: Osteoporosis and the propensity to fall determine to a large extent the occurrence of hip fractures. Prevention of osteoporosis and fractures, particularly among older individuals aged 80 and over, may in turn have an impact on mortality, morbidity and quality of life. . In Denmark, a two-year programme targeting 23.000 elderly people resulted in a 46% reduction of fractures. We may note three pilot schemes across England aimed at getting older people more involved in preventing falls. Another initiative in Austria aims to prevent accidents among the elderly aged 60 years and above.

The principle of active ageing has been recognised in several countries and ad hoc programmes have been implemented (e.g. Austria, Germany, Finland, Sweden) to promote the empowerment process of older people. In Sweden alone, the concept of empowerment is integrated in the national objectives for elderly people. Generally, these initiatives combine community interventions and personalised actions.

Several countries, e.g. Sweden, Austria, Finland, Germany and the United Kingdom have adopted the concept of independent living and integrated it in specific programmes. The idea is to delay the onset of disease and the referral to care services.

Several countries have noted the need to complement national strategies by specific actions aiming at reducing health related inequalities. Such policies are proposed notably in the UK, France, Netherlands and Sweden.

3.3 Volunteer work and health

3.3.1 National policies

Before to analyse national policies, it is interesting to present the main funding sources of volunteering.

The government is the main source of money in Belgium and the Netherlands. Public funds and fees are prevalent for Austria and Germany. The main sources of financing are fees in Italy and Poland. Fees and philanthropy model is prevalent in Finland and Spain, while in France almost half of total revenues comes from philanthropy.

Source of revenue in civil society sector varies between countries. On average, governments are the greatest financiers by providing 37% of total revenues, this percent is lowest in Spain and Poland, approximately 25%, and highest in Belgium 66%. Almost as much come from fees.

Belgium

Within Belgium, volunteers are involved in numerous activities in a range of sectors concerned with the economy, health, leisure, culture and the environment etc. There are however some activities that are more popular than others. These fall under the banner of “social action” (helping those in difficult situations, for example refugees and the socially excluded) and sports activities.

The main objectives and target groups include:

- Increasing the professional efficiency of professionals and volunteers
- Increasing the effectiveness of senior citizens (as consultants and assistants to younger and older persons) and their ability to live independently, so that they can live as long as possible in their familiar home surroundings and participate in all social activities in the community.
- Strengthening social cohesion: younger and older people together studying the process of ageing in our society increases mutual understanding and inter-generational solidarity.
- Providing a background vision to all important players and in particular to general care providers and active volunteers in organizations.

One recent trend in Belgium is the increasing professionalisation of the voluntary sector and volunteerism: not only are volunteers increasingly skilled which helps to improve the working techniques of voluntary sector associations, but volunteerism itself is becoming increasingly professionalised in the form of more research into volunteerism, volunteer management, training and infrastructure etc.

Germany

The National Survey on Volunteering (2004) differentiated 14 fields of activity. The most common voluntary activities performed were related to *organising and conducting meetings* followed by *work that needs to be done*. Areas that are more directly related to social and political engagement comprise fewer citizens, and the major tasks in this area are mostly done within a party or a trade union.

Activities may be performed in the frame of formal or informal organizations. The executive responsibility for volunteering is split between the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth and the relevant Ministries of the States (social ministry or the ministry of internal affairs). Several states are running campaigns or programmes to promote or support voluntary work. The voluntary sector is marked by a structural heterogeneity.

Currently there are approximately 150 of regional volunteer agencies or centres across Germany. In addition to the volunteer centres, there are around 120 special agencies for active senior citizens, so called senior offices. Furthermore, there are numerous offices for information and support of self-help and mutual aid groups. Under the principle of subsidiary the non-for-profit organisations can claim public financial support.

The financial situation of the volunteer agencies seems to be difficult. There is still no federal funding of volunteer agencies. The current statutory accident insurance and third-party liability for citizens volunteering ought to be extended to cover further fields.

France

Government recognition of volunteering takes the form principally of the National Funds for the Development of the Non-Profit Sector. This fund exists to support research into the sector and to offer training on the sector. Subsidies to organisations to support their activities are channelled via local authorities.

The Ministry of Social Affairs, Labour and Solidarity has financed some of the operations of the national volunteer centre in the past; this income has been supplemented with private donations and over one third from their own resources.

The system of early retirement pension entitlements has a positive effect on the participation of older people in voluntary activities.

The French volunteer has been viewed as a necessary complement to the State in confronting the budgetary crisis of the French State and therefore has been promoted by State. For example, employers must give employees who are member of an association and who represent it, the permission to take of the necessary time to participate in meetings. This is called “Representation Days Off” for volunteers.

Everyone active in volunteering for at least 3 years may ask that his or her experience be validated, i.e. to get a diploma or a certificate.

Spain

The role of the government in Spain in relation to volunteering is mainly to be an agent for promoting and supporting voluntary activities. At national level, however, there is no governmental department focused on volunteering issues. The Minister for Work and Social Affairs is the main actor in the promotion of volunteering, and the Ministry for Youth also takes part in it.

At the regional level, in most of the seventeen Spanish Autonomous Communities there are regional federations or centres that gather volunteer associations and organisations active in their territory with a view to promote and support volunteering. Finally, at local level, authorities of many cities carry out actions to inform and train volunteers.

With regards to funding of volunteer organisations and regional volunteer centres in Spain, financial resources come, first of all, from public authorities and to a lesser extent from private donations. Secondly, most volunteer organisations and agencies have to face financial hardship. Another important feature of volunteer work in Spain is its high level of professionalism.

Volunteering is still relatively small and weak compared to other countries in Western Europe. Nevertheless, the involvement of the State in the regulation of volunteering in Spain has progressively increased in the recent years. Both national and regional governments in Spain have recognised

volunteering from a legal point of view. Other policy initiatives at national level are the State Plans on Volunteering that the national government has elaborated.

The encouragement of volunteering should specially focus on two different groups, whose participation in volunteer activities is still very low: old/retired people and unemployed. Secondly, most volunteer organisations and agencies have to face financial hardship. Indeed, there is a need of more public expenditure and funding for volunteering and volunteer agencies/organisations. The activities and resources of voluntary organisations might be more and more limited and, therefore, lead to a diminution of volunteering in a mid and long term.

Netherlands

An important development in Dutch civil society is the rise of 'checkbook participation' and the growth of tertiary organizations that do not require face-to-face contacts. In the Netherlands, charitable giving by households has increased enormously in the last decades. Charitable donations may be less demanding than active membership or voluntary work because they require less time. However, in the Netherlands charitable giving has not increased as a compensation for the lack of active involvement in voluntary associations. Relationship between giving money and giving time is not compensatory. (Bekkers 2004.)

To ensure sufficient participation of older people in volunteer work and civil society, various organizations - including local authorities and the Netherlands Organizations Volunteer work (NOV) - have developed many new initiatives in recent years, building on a variety of strategies. Some of these have given way to new roles and functions being developed for older people or to senior volunteers being given more cope to work according to their own insights and initiatives within organizations. Other strategies seek to enhance opportunities for older people to provide support and advice to younger volunteers. (Factsheet, Senior Citizens in the Netherlands).

Recent cutbacks in government subsidies for nonprofit organizations will increase membership fees. These developments will probably increase social inequality in civic engagement and reduce the potential for social integration of civil society. To make participation in voluntary associations more attractive for the lower educated, and to make the lower educated more valuable as volunteers, opportunities should be provided to gain knowledge and skills through training programs within voluntary organizations. This might not be possible because of the cutbacks (Bekkers 2004.)

Austria

The Austrian government has in recent years amplified its efforts to promote voluntary engagement. But not only the Austrian government considers volunteering as important, but also Austrian business does. The economic value created by volunteering is huge and volunteers and business commonly recognise the utility of volunteering both for society as a whole and for the individual volunteer. The importance of the personal dimension of volunteering is rather new.

Older people represent a huge potential for intergenerational voluntary work. The more this is utilised, the more evident it becomes that senior citizens are not merely passive contribution recipients, but active contributors to society themselves. This voluntary work is not only indispensable for the community; it also offers older people who have retired the opportunity to find meaning and fulfilment in their lives, thus fulfilling the intention of active ageing. (Center for Population 2006.)

In the last few years, 28 Citizens Offices for Young and Old were established with the support of the Federal Ministry of Social Security, Generations and Consumer Protection in almost all Austrian provinces. The Citizens Offices act as centres for people who want to do voluntary work or make enquiries. At the same time, they are platforms for autonomous groups and initiatives, which work for the benefit of the community and for which active cooperation in the region is a matter of concern

A central function of the Citizens Offices for Young and Old with regard to voluntary services policy is that in this way supply and demand for voluntary engagement can be brought together at a local level. This important function of the Citizens Offices is being developed in a targeted way by the establishment of regional volunteers exchanges. The interactive database on the website www.freiwilligenweb.at offers an overview of the existing Citizens Offices and serves as support for the coordination activities of the Volunteers Exchanges.

Austria has a rich civil society and volunteering is a phenomenon that is well anchored in the Austria civil society. The Austrian government has in recent years amplified its efforts to promote voluntary engagement.

Poland

Volunteerism constitutes the main component of the non-profit sector in Poland. The main tasks carried out by volunteers within these organisations are of organizational nature (organisation of meetings, events etc.).

According to Law on Public Benefit Activity and Volunteerism, with respect to health care, a volunteer carrying out a service in the framework of this law is automatically covered by the general national healthcare insurance. In case of accident while performing a volunteer activity, the individual is entitled to compensation⁹³.

The lack of financial resources is a frequent and common problem with a great impact on the progress of voluntary work and the Third Sector. Another problem was constituted by the too bureaucratic public administration and complicated formalities related to applying for subsidies from sponsors, public programmes and European funds⁹⁴.

Finland

In Finland, municipalities are responsible for organizing welfare services to the people living in their area. Municipals can buy these services from organizations. There are 32.500 paid workers working in these organizations. Furthermore, there are 180.000 people doing benevolent work for these organizations.

In Finland the public sector still remains the main provider of social health services. Finnish voluntary organizations have somewhat minor roles in providing and producing social and health services but the state supports them financially. Lately voluntary sector has become more visible, embarking on a shift from the marginal position to a networking position. Half of the voluntary social and health association is funded by the public sector although the funding varies remarkably in single associations. (Helander & Laaksonen 1999, Melin 1999, see Nylund 2000.)

Raha-automaattiyhdistys (Finland's Slot Machine Association), which is generally referred to as RAY, raises funds through gaming operations to support the work of voluntary health and welfare organizations. Many health and welfare organizations depend on the Ray funding. Municipalities buy from these organizations health and welfare services⁹⁵.

Volunteering usually takes place in associations. But this is not necessarily so. In fact, only about two third is volunteering in associations (Pyykkönen 2002, 93), one third takes a more loosely organised form such as neighbourhood and informal help or bees. On the other hand the activity of associations is not always about volunteering (Hilger 2006.) It seems that majority of people volunteer out of

⁹³ Source: AVSO & CEV Project: Legal Status of Volunteers: Country Report: Poland

⁹⁴ Voluntary Action in Poland - Facts and Figures. European Volunteer Centre 2005

⁹⁵ <http://www.ray.fi/inenglish/index.php>

personal interest and because of their ideologies, not because of structural changes in society (Nylund 2000).

If volunteering is regarded as a paid employment (Income Tax Act 71§ 3 sub-item) and by virtue of this subsistence money is taxed, this may diminish the motivation of the volunteers in case they are very active or live in periphery. (Volunteering, peer support and competing 2004). Restrictions of the minimum distance between 'work place' and home that justify compensation, and lower travel expense compensations than received when a person is in paid work may also decrease motivation.

One of the most frequent and at the same time most tangible complaints refers to travel expenses. It is seen as a burden that volunteers who already contribute with their time sometimes also have to pay themselves when travelling to a customer or 'voluntary workplace'. This is one of the most common complaints that indicates where support could be needed (Hilger 2006.) On the other hand, in some cases compensations may diminish the motivation to volunteer. In few voluntary works, such as volunteer fire-brigade, rescue services and lobbying, a voluntary may be compensated for his or her contribution. However, if compensation for volunteering reduces volunteer's incomes such as unemployment benefit or pension it may decrease motives for volunteering.

Sweden

There is no legal framework or specific governmental policy for volunteering⁹⁶;

Despite the long tradition of volunteering, it is only during the last 15 years that volunteer centres and agencies have emerged. There is no specific law governing non-profit organisations. Sports constitute the first field for volunteer work. Less people volunteer in social organisations. Social voluntary actions seem to be most common among pensioners. Also, almost all of the volunteer centres have pensioners and around half have people with illness or activity compensation as volunteers (Socialstyrelsen, 2007)⁹⁷. Older people are overrepresented.

During the 1990s the non-profit organisations working in the social area gained greater attention and significance than formerly, both as partners to the municipal social services and as direct providers.

For an unemployed person, volunteering may lead to a loss of unemployment benefit. Also the Social Insurance Office, in certain cases, might consider volunteering by long term sickness beneficiaries as work. This is a serious barrier to volunteering by people with chronic illness or disability. What makes a person lose his/her rights to the benefits is the performance of such efforts that are equivalent to those, which a person who is working gainfully normally performs⁹⁸.

Local authorities may provide grants, notably to regional volunteer centres; there is no tax reduction for grants to non-profit organisations as in several Member States (e.g. Belgium, Denmark, UK, etc.).

United-Kingdom

Volunteering in the UK has a long tradition and is culturally accepted and seen as worthwhile by both the public and Government policy-makers. As for government policies, the "Compact on Relations between the Government and Voluntary and Community Sector" was established in 1998. This framework document sets out the basis for mutual cooperation between the two at both national and local levels. In addition, the UK Government is increasingly recognising the important role the voluntary sector and volunteers can play in the delivery of public services, such as social care, housing, education and health care. The United Kingdom has seen significant interest and investment

⁹⁶ Volunteering in Sweden – Facts and Figures Report; European Volunteer Centre, 2007

⁹⁷ Socialstyrelsen, Report by the National Board of Health and Welfare, 2007

⁹⁸ <http://www.riksdagen.se/webbnav/index.aspx?nid=71&dtyp=frs&rm=2006/>; Sveriges riksdag, Stockholm, 2007

in volunteering over recent years, including in infrastructure agencies, information and communication technologies, glossy new volunteer programmes and awards. Volunteering is seen as vital to fulfil a range of government and public interest objectives. This will ensure that volunteering, in the near future at least, will remain firm on the political agenda in the UK.

According to Evaluation Report (Ellis 2004) all older volunteers of the GIA programme enjoyed a very good quality of life and were very positive in both outlook and the work they diligently committed to through the GIA scheme. The evaluation also indicates that many rediscover old skills, learn new things, and become more aware of their own needs and the needs of the young people they come in contact with in the wider community. The volunteers also gain in confidence, find companionship and enjoyment through their work.

The national and regional volunteer centres are Volunteering England, Volunteer Development Agency of Northern Ireland, Volunteer Development Scotland, and Wales Council for Voluntary Action. Volunteering England is financed by a variety of corporate supporters, trusts and foundations. Volunteering England provides grants to local health and social care projects in England that involves volunteers in the delivery of their services. All volunteer centres in Scotland benefit from funding from the Scottish Executive, and, for example, from local councils, local health trusts, and local enterprise companies.

A number of concerns can be identified, among them the lack of quality evidence on volunteering, the failure to adopt consistent definitions of volunteering, a reluctance to set targets for certain sectors and agents (e.g. the private sector), and an avoidance of realising the costs of volunteering and of recruiting, supporting and retaining volunteers.

3.3.2 Comparative analysis

The economic value created by volunteering is huge and public authorities and businesses recognise the utility of volunteering both for society as a whole and for the individual volunteer. The importance of the personal dimension of volunteering is rather new.

Volunteering in the UK has a long tradition and is culturally accepted and seen as worthwhile by both the public and Government policy-makers. Similarly, in Austria its value is accepted by both the government and business. This will ensure that volunteering, in the near future at least, will remain firm on the political agenda in these countries.

Volunteering is seen as vital to fulfil a range of government and public interest objectives (e.g. United Kingdom). Also, volunteer has been viewed as a necessary complement to the State in confronting the budgetary crisis and therefore has been promoted by State (e.g. France).

Employers may give employees who are member of an association and who represent it, the permission to take of the necessary time to participate in meetings. This is called “Representation Days Off” for volunteers (e.g. France).

Also, a volunteer carrying out a service in the framework of the law might be automatically covered by the healthcare insurance. In case of accident while performing a volunteer activity, the individual is entitled to compensation (e.g. in Poland).

Everyone active in volunteering for a minimum length of time may ask that his or her experience be validated, i.e. to get a diploma or a certificate (e.g. France)..

Volunteering is still relatively small and weak in certain Member States (e.g. Spain) compared to other countries in Western Europe. Limited financial resources may be an additional obstacle.

Table III.7: Summary of key national instruments / policies

	Type of volunteering	Civil society sector sources of support	‘active ageing’ programs and associations
Belgium	Culture:34% Health&social:66% Civic:1% Education:1%	Government:66 Philanthropy:18 Fees,dues:16	Increasing the efficiency of senior citizens (as consultants and assistants to younger and older persons) Strengthening social cohesion: younger and older people together.
Germany	Culture:41% Health&social:19% Civic:6% Education:2%	Government:43 Philanthropy:36 Fees,dues:21	Several states are running campaigns or programmes to promote or support voluntary work.
France	Culture:47% Health&social:19% Civic:2% Education:10%	Government:33 Philanthropy:47 Fees,dues:20	The system of early retirement pension entitlements has a positive effect on the participation of older people in volunteering. The French volunteer has been viewed as a necessary complement to the State in confronting the budgetary crisis of the French State
Spain	Culture:22% Health&social:36% Civic:11% Education:12%	Government:25 Philanthropy:36 Fees,dues:39	Volunteering is still relatively small and weak. Both national and regional governments in Spain have recognised volunteering from a legal point of view.
Netherlands	Culture:39% Health&social:30% Civic:7% Education:16%	Government:46 Philanthropy:24 Fees,dues:30	Rise of ‘checkbox participation’ and of tertiary organizations that do not require face-to-face contacts. Giving money and giving time is not compensatory.
Austria	--	Government:41 Philanthropy:23 Fees,dues:36	The Austrian government and business consider volunteering important. Rich civil society and volunteering well anchored in the Austria civil society. The Austrian government has in recent years amplified its efforts to promote voluntary engagement.
Poland	Culture:37% Health&social:33% Civic:1% Education:17%	Government:23 Philanthropy:20 Fees,dues:57	According to Law with respect to health care, a volunteer carrying out a service is automatically covered by the general national healthcare insurance.
Finland	Culture:48% Health&social:25% Civic: 24% Education:2%	Government:25 Philanthropy:35 Fees,dues:40	The government provides public funds.
Sweden			
United Kingdom	Culture:31% Health&social:34% Civic:3% Education:5%	Government:36 Philanthropy:29 Fees,dues:35	Volunteering is seen as vital to fulfil a range of government and public interest objectives. This will ensure that volunteering, in the near future at least, will remain firm on the political agenda in the UK.

Source: Eurostat, Activage

To ensure sufficient participation of older people in volunteer work, various organizations - including local authorities - have developed new initiatives. Some of these have given way to new roles and functions being developed for older people or to senior volunteers being given more cope to work according to their own insights and initiatives within organizations (e.g. the Netherlands).

Other strategies seek to enhance opportunities for older people to provide support and advice to younger volunteers (e.g. Netherlands). Similarly, certain countries (e.g. Belgium) have taken into account expressly the role of senior citizens in their programmes (as consultants and assistants to younger and older persons). Both strategies stress the importance of social cohesion: putting together

younger and older people in our society might increase mutual understanding and inter-generational solidarity.

Several states (e.g. in Germany) are running campaigns or programmes to promote or support voluntary work.

The system of early retirement pension entitlements has a positive effect on the participation of older people in voluntary activities.

In the Netherlands, charitable giving by households has increased enormously in the last decades. Charitable donations may be less demanding than active membership or voluntary work because they require less time. However, the relationship between giving money and giving time is not compensatory.

3.4 Conclusions

A large number of national activities promote active ageing, notably:

- Active and healthy ageing is increasingly taken into account in national health promotion programmes
- Promotion of physical activities, education and participation in cultural events
- Organisation at a regional or local level in cooperation with the informal sector
- Proximity with clients aims to favour the diffusion of healthy lifestyles and education among disadvantaged groups
- National information campaigns have been organised in several Member States.

Volunteering can be one important element for active ageing. Several Member States promote volunteering in their health promotion programmes.

- Older people represent a huge potential for intergenerational voluntary work
- Public authorities and businesses recognise the utility of volunteering both for society as a whole and for the individual volunteer
- Volunteering is seen as vital to fulfil a range of government and public interest objectives or as a necessary complement to the State in confronting the budgetary crisis
- The importance of the personal dimension of volunteering is rather new
- Complaints refer to participation cost (e.g. travel expenses) which does not receive a favourable fiscal treatment.
- If compensation for volunteering reduces volunteer's incomes such as unemployment benefit or pension it may decrease motives for volunteering.

Measures to promote volunteering include:

- the permission to take of the necessary time to participate in meetings,
- automatic coverage by the healthcare insurance, and

- validation of experience as volunteer.

However, limited financial resources may be an additional obstacle.

III.4. Labour market participation and informal caring

4.1 Introduction

Guideline 18 in the employment guidelines on gender equality concerns “Reconciling work and family life”. The main objective of this guideline is to adopt family-friendly policies in order for women and men to be able to reconcile their work and family life. The reconciliation of work and family life is facilitated by the availability of care services for children and frail elderly people. The Conclusions of the Lisbon summit of 23-24 March 2000 confirmed the need of making it easier to reconcile working life and family life.

4.2 National policies

It seems that care responsibilities and labour market participation compete for available time budgets. It was observed that care and labour market participation have a negative relation in all European countries. However, in some countries this relation is striking in others minimal.

It is true that countries with the highest labour market participation also have the highest rate of working informal carers (Denmark, Finland). However, general high labour market participation does not imply a high labour market participation of carers (e.g. Portugal, France).

The importance of reconciliation of work and care has to be stressed as policies to take dependent people out of closed institutions, whenever possible, and to promote living at home are followed in all European countries. Most of them cover elderly people too. Countries who favoured in the past institutionalisation are currently reversing their policies. The objective of keeping people at home is the same in all member states but the underlying logic is different. In Nordic countries, de-institutionalisation may be an important reason, while in Mediterranean countries the lack of infrastructures might be the main reason.

In the following, we will present an overview of national policies affecting directly or indirectly work of informal carers.

Belgium

On a federal level, there is no specific legislation regarding long term care in its entirety. The introduction of a long-term care insurance at a federal level, or at the level of federal entities other than the Flemish Community, is not currently planned for the near future⁹⁹.

Belgium (Flanders) introduced the dependency insurance in 2002. It is a mix combining a mandatory personal contribution and funding by public resources. Its unexpected success led to a reduction of benefits and a rise of contributions.

In 2004, the Federal government introduced a system of ‘service cheques’, in which people can pay for household help. Moreover, it offers compensations to elderly people for lack of ability to do things independently. The money can also be used to pay an informal carer. Social security is financed mainly by social contributions.

⁹⁹ 1) Public federal service of Social security : <http://socialsecurity.fgov.be/FR/index.htm> 2) Flemish long term care (Zorgverzekering) : <http://www.wvc.vlaanderen.be/zorgverzekering/>; 3) Declercq, Anja and van Audenhove, Chantal (2004).

There is no legal obligation for families to provide care for older family members. However, they can be legally obliged to help finance residential care of a parent or grandparent.

The government's policy is to enable family carers to accommodate caring with a professional career. It is done by introduction of special arrangement in the work place, like 'Leave for compelling reasons' (each employee can take up 10 unpaid days a year), 'Leave without pay', 'Interruption of career for giving medical assistance' or 'Interruption of career for palliative leave'. However, still much depends on the willingness of the employer and on the financial possibilities of the caregiver, since the financial compensations are rather low.

Denmark

Everybody living in Denmark is entitled to receive care, whatever their age. The local authorities have a duty to propose assistance and personal care, as well as a practical assistance in the house. There is an extensive provision of home care. All people needing a home help are entitled to choose from the various suppliers of domestic services. Institutional care is also developed. This reduces the need for informal care. The local authorities also have the possibility of proposing support to spouses or other family members caring for a terminally-ill or seriously-ill person.

Concerning informal care, the government is currently proposing to introduce new mechanisms to encourage a change in attitude and to give the citizens a wider possibility of choice among the private and public solutions.

In general, conditions for carers to combine work and care – or family life in general – are looking good in Denmark. There is a high willingness to spent money on the provision of universal services to enable work and family life. Policies clearly prioritise gender equality and high labour market participation over cost reduction in care. In the future, an issue might be cost control and availability of carers, due to demographic development.

Labour market participation of carers compared to non-carers – of our sample - is highest in Denmark. Having a closer look it can be stated that Denmark has a different policy approach towards long-term care (and care in general) than the other countries of the sample.

Extensive public domiciliary services are provided by the state (or by state funded private organisations) through the municipalities in the form of "home help" to the elderly. These services are universally accessible and tax financed. In Denmark dependents have the choice between receiving a specified service or an allowance to pay for it.

Family care exists also, but there is a division in type, scope and scale between family care and state provided services. Home help is mainly covering personal care and basic cleaning whereas family care can be seen as stimulation to remain socially active and minor support in daily activities. Assistance in shopping, gardening, paper work, and similar activities is considered as family care. Thus, there are totally different perceptions and experiences of family care in Denmark and other countries. Personal care is seen as the responsibility of the state and not of family and friends.

Germany

Social insurance on long-term care as the fifth "pillar" of social insurance ensures that for citizens the risk of "long-term care" is protected comparably as for the risks of illness, accident, un-employment as well as protecting income in old age in one single social security system. Every health insurance fund has a long-term care fund, which implements a social insurance on long-term care. It should therefore be differentiated from an individual's other insurance entitlements, which are based purely on illness and are therefore to be categorised under health insurance (e.g. entitlement to help in the home or long-term care in the home in the event of illness or to avoid a stay in hospital). Long-term care

insurance benefits are granted depending on the extent of the long-term care requirement, but also depending on age, income and wealth¹⁰⁰.

The main instrument regulating long term care in Germany is the “long term care insurance”. The insurance was introduced to (a) relieve communal budgets spending money for care needs related social welfare, (b) financial relieve for care receivers and care givers and (c) strengthen priority of home care. Thus it was not introduced to facilitate labour market participation of carers but it can be assumed that it has an impact on the issue. Persons entitled to benefits are relatively free on choosing professional services or family members providing the care.

The legislator is aware of the fact that home carers often fully or partially give up their own job to care for a family member. To compensate negative financial effects long-term care insurance providers make contributions to the statutory pension insurance for home carers.¹⁰¹ Thus the long term care insurance does not really fosters labour market participation of carers but influences the decision of caring or not caring as financial compensation is granted for the carers.

Flexible working time arrangements are mostly available, thus the arrangement of part-time work and home care are widespread, especially for women.

People can choose between cash benefits, in kind benefits or a combination of both. The definition of long term care in Germany is somewhat narrower compared to others countries. However, the program continues to maintain broad popular and political support.

Further, respite care, short term care are also available to relieve home carers.

Times of long term care provision are considered for old age pension benefit contribution. Protection without contribution is also provided by the accident insurance. Germany’s Long-Term Care Insurance System provides for pension credits for each week the benefit is received.

The assessment of eligibility for Long-Term Care Insurance was initially criticised for its bias in favour of older people with physical, rather than mental health problems. A recent reform (the Dementia Care Act 2002) therefore provides additional LTCI benefits for people with cognitive impairments, in order to alleviate the stress on their carers.

Long-Term Care Insurance has also stimulated a growth in more flexible home care services; since 1992, the number of home care agencies has increased from 4000 to 13,000. This is in turn reflected in the growing numbers of LTCI beneficiaries who now opt to receive at least part of their benefits in kind rather than cash (up from 12 per cent in 1995 to 35 per cent in 2002)¹⁰².

Spain

The general government policy is that the care of dependent elderly people is the family’s responsibility. The elderly people are kept at home for as long as possible. Spanish civil regulations assign the responsibility for attending and caring for the dependent elder to the spouse and children¹⁰³.

¹⁰⁰ 1) Federal Ministry for Employment and Social Affairs: Overview of social law, Nuremberg 2006; 2) Federal Ministry for Health and Social Security: Third report on the development of long-term care insurance, Bonn 2004.

¹⁰¹ However, the amount is relatively low, some critics speak of a symbolic function (Barkholdt and Lasch 2004)

¹⁰² Support for carers of older people – some intranational and national comparisons: A review of the literature prepared for the Audit Commission, Caroline Glendinning, National Primary Care Research and Development Centre at the University of Manchester; Audit Commission, UK, 2004

¹⁰³ 1) Spanish Ministry of Labour and Social Affairs: White Book on Dependence; 2) EU Commission, MISSOC: Studies on Long term Care: Spain; 3) Larizgoitia Jauregi, Arantza (2004).

In the *Plan of Action for the Elderly*, the Ministry of Employment and Social Affairs establishes an area of action towards elderly people, namely 'equal opportunities', which includes the aim of developing policies of protection of the elderly in situation of dependence.

Problems of the working carer started to be perceived only recently. A later revision of the legal code gives the right to a reduction of working hours with a proportional reduction of salary, and/or leave for a time not exceeding one year to look after a relative who, for reasons of age, is unable to look after him/herself. The government participates in financing care for the elderly with an income deduction on carers

In this regard, the Act 39/1999 on reconciling family and working life provide for the possibility of granting up to one-year leave to the carer of a relative on account of an illness (including dependence) or old-age (assistance to elderly persons). Although the post is reserved during the period of leave, there are no benefits to compensate for the time dedicated to providing care, with the exceptions and possibilities established to that effect, and the social security contributions are not financed either.

In the Region of Catalonia, workers in care of a disabled relative or handicapped elder may reduce working time by 33% with 80% of salary or working time by 50% with 66% of salary.¹⁰⁴

The Law 39/2006, of 14 December, concerning the promotion of personal Autonomy and Care for persons in a situation of dependency, grants a subsidy to elderly and disabled, not receiving a help from other public funds. It requires the assistance of another person for the accomplishment of the most essential activities of daily living, and not to be admitted in a centre.

France

According to government's policy the family is expected to provide care. Children are legally obliged to undertake the maintenance of their parents and other ascendants. The French government had replaced the term 'family carer' with 'natural carer'.

Since 2001, this involves the allocation of a Personal Autonomy Allowance (APA), which aims at enabling elderly people to cope decently with the financial costs linked to their loss of autonomy, whether they live at home or in an institution. This is not a branch of the social security, but a national solidarity allocation. This allocation is awarded to people aged 60 or more who are unable to cope with the consequences of the lack or loss of independence brought about by their physical or mental condition and who need help to carry out the essential activities of life or whose condition requires regular attendance. The 2005 Law replaced it by Prestation Spécifique Dépendance (PSD)¹⁰⁵.

Although it is paid in cash, the personal autonomy allowance is a benefit in kind, as it is a reimbursement of actual expenses incurred. It is paid each month directly to the beneficiary who must prove that it is actually allocated to financing measures from the assistance programme (for example assistance in the home, hours of home-help services, meals delivery services, hours of supervision in the home, technical assistance: chair, medical bed, adaptation of housing, etc).

The 2005 Law established the Compensatory allowance for third person. Beneficiaries are people with disabilities aged between 16 and 60 years. Those over 60 may claim Prestation Spécifique Dépendance PSD (ex APA). It aims to compensate the supplementary expenses related at the employment of a person at the residence of a disabled person or the supplementary expenses generated

¹⁰⁴ Barkholdt and Lasch 2004

¹⁰⁵ 1) DREES, ÉTUDES et RÉSULTATS ; N° 514 • août 2006 : LES BÉNÉFICIAIRES DE L'AIDE SOCIALE DÉPARTEMENTALE EN 2005. 2) ÉTUDES et RÉSULTATS, n° 554 - février 2007 ; Le compte social du handicap de 2000 à 2005

by the fact that the person that takes care of the handicapped person can not exercise another remunerated activity.

Other provisions include: Leave of absence or part-time employment for attending a dying person wage-earners (relative or member of household) and Job return guarantee.¹⁰⁶

Netherlands

In the Netherlands, the risk of needing long term care has been covered by a specific branch of the social security system since 1968. The Exceptional Medical Expenses Act (in Dutch: AWBZ) was intended to provide for the considerable financial consequences of serious long-term sicknesses or disorders, in particular the costs of caring for disabled people with severe congenital physical or mental disorders and psychiatric patients requiring long-term nursing and care¹⁰⁷.

A basic principle of the Exceptional Medical Expenses Act is that people should continue to live at home for as long as possible. They can receive care either in the home or at a health-care institution. Instead of home care a cash benefit can be granted which is called “Personal Budget”. If the client is receiving a personal care budget, his/her personal contribution is deducted directly from the budget.

In the Netherlands, 60% of informal caregivers are active on the labour market. The Dutch government is well aware of the labour market impact and focuses attention on good conditions to combine work and care.

At present, there is a limited possibility to take care leaves. The arrangement for Financing Career break (since 1998) offers the possibility for a palliative care leave. A new, unique arrangement for work leaves - the life course arrangement started in 2006.

Non financial support includes: Civil servants have a restricted entitlement of short- and long-term-care leave in case of a serious illness of a close relative. For workers there are no public regulations but arrangements in collective agreements.¹⁰⁸

Austria

The Federal Long Term Care Benefit Act¹⁰⁹ - and the accompanying regional laws – created a uniform long term care system for the more than 360.000 people currently requiring long term care and the disabled. In parallel with this, an agreement was concluded between the Federal Government and the regional states on joint measures by the Federal Government and the regional states for people in need of care.

The government’s policy assumes that family care is indispensable and care should be provided at home as long as possible. Under civil law marriage partners are legally responsible for each other’s maintenance. Within certain limits the elderly can also claim maintenance from their descendants.

In 1993 the *Federal Long-Term Care Allowance Act* (LTC) was introduced. The allowance has a form of a single cash payment. The government does not monitor how beneficiaries spend the money and it is evident that benefits quite often are passed to family caregivers. This consumer-driven home care and empowerment philosophy system gives elderly people control over who provides services.

¹⁰⁶ Barkholdt and Lasch 2004

¹⁰⁷ 1) Dutch Ministry of Health, Welfare and Sport:

<http://www.minvws.nl/en/folders/z/2005/health-insurance-in-the-netherlands.asp>; 2) Visser-Jansen, G. and Knipscher, C.P.M. (2004).

¹⁰⁸ Barkholdt and Lasch 2004

¹⁰⁹ Federal Ministry for Social Security, Generations and Consumer Protection: The provision of care in Austria, Vienna 2006; and Hörl, Josef (2004).

In 1999 *'National Plan for Senior Citizens'* was developed, which provides a basis for political decisions in the field of elderly policy. The government's policy aims at supporting informal care by development of model of shared responsibility between the family and social service organizations.

General policy towards caregivers is to integrate them strongly into the local care framework and to give them permanent support. Working carers are eligible for a care leave for up to a maximum of one working week per year. Under special exceptions tax deductions on extra cost connected with caring are allowed for family carers. Since 2002 persons caring for dying family members are legally entitled to compassionate leave/family hospice leave. There are preferential terms for the insurance of persons providing long-term care who are unemployed - they can take out self-insurance under the health and pension insurance schemes.

Since 1998 there is a preferential additional insurance in the pension insurance scheme for those people who are looking after a close relative in their home entitled to the long term care benefit and who had to give up their gainful employment for this reason. These people are granted preferential treatment to the extent that the Federal Government assumes the fictitious employer contribution and the carer therefore does not have to pay 22.8 %, but only 10.25 % of the assessment basis as a contribution¹¹⁰.

People, who care for a disabled child living in their home and whose full capacity for work is taken up completely for this reason, may claim a preferential personal insurance in the pension insurance scheme: the contributions to this insurance are borne fully from the funds of the Equalisation Fund for Family Assistance.

Since 2006, in addition to the above-mentioned social insurance statutory protection for carers who are relatives, a preferential personal insurance for periods of care for close relatives was created (see detailed description in next Part on best practice).

In 2002 employees could opt for a family home care leave allowing them to be absent from work or to reduce their working time temporarily in order to accompany dying relatives or seriously ill children living in the same household. A support option for this leave through a solidarity fund was established to provide a cushion for the loss of income as well as accompanying measures in the field of the Federal Long Term Care Benefit Act, such as the opportunity for an alteration to payments of the long term care benefit and the option of awarding flat-rate advance payments for a future long term care benefit for pending procedures to grant or increase these allowances etc.

The budget accompanying law of 2003 also created the option within the Federal Long Term Care Benefit Act to grant an allowance as of 1st January 2004 to a close relative, who is the main carer for a person requiring care receiving a minimum long term care benefit for at least one year and who is unable to provide care as a result of illness, holiday or another compelling reason from the Support Fund for the Disabled. The allowance is intended to represent a contribution towards those costs incurred by the main carer because he is unable to provide care (e.g. as a result of illness, holiday or educational courses) for a professional or private replacement carer. Applications for the granting of an allowance should be submitted to the Federal Welfare Office.

In addition, semi stationary care and nursing home care services are available, provided by public and private providers. Available outpatient services include: home help, qualified caregiver, visiting service, organised neighbourhood help, mobile therapeutic services, family help, counselling of relatives, lending of nursing aids and appliances, laundry services, cleaning services, repair service, transport service, personal assistant. Further, counselling and information services are available.

¹¹⁰ Federal Ministry for Social Security, Generations and Consumer Protection: The provision of care in Austria, Vienna 2006.

A family carer can claim one week care leave a week. Also, employees with temporary care obligations has a right for part time work with right to return to full working hours after termination of care.¹¹¹

Poland

In Poland¹¹², there is no integrated, long-term care system regulated by law. People who need such care are entitled to certain benefits under various legal acts.

It is the obligation of local government authorities of all levels to ensure adequate living standards to all persons who require long-term care. The family, despite its own efforts, is not always in a position to provide adequate care. Therefore, care (attendance) and specialist care services, including those for people with mental disorders, is one of the basic forms of assistance in kind.

Under the Polish family law adult children have financial obligations towards their elderly or disabled parents. A general principle provides that assistance to individuals who need long-term care should be provided in the family environment as long as possible. At this end, facilities are organised for attendants of persons who require such care.

Pursuant to the Act on Social Assistance, a social assistance centre pays the contribution to old-age and pension insurance for a person that gives up employment due to the necessity to exercise direct, personal care for a member of the family suffering from a long-term or serious disease, and for non-cohabiting mother, father, or siblings, under certain conditions. The above also refers to individuals who – due to the necessity to exercise such care – are on an unpaid leave.

As regards attendants – volunteers, the provisions of the Act on Public Benefit Activity and Voluntary Work of 2003 apply accordingly. Pursuant to this Act, a volunteer may be entitled to health benefits according to the terms as provided for in the provisions on health care benefits financed from public funds. They are also eligible for benefits due to any accident in performing the services, and where a volunteer provides services for a period not exceeding 30 days, the beneficiary is obliged to ensure personal accident insurance to that volunteer.

Furthermore, attendants of persons who require long-term care and have an official statement assessing disability are entitled to pay fares at a reduced rate while travelling with persons entrusted to their care.

There is one legal regulation, which grants the family carers of disabled the right to a two-week leave, if the carer is employed on the basis of an employment contract.

Slovenia

Slovenia does not have a uniformly arranged system of long-term care, but various services and benefits are provided under the existing systems of social protection. Long-term care is developing but lacks systematic regulation. Therefore the government is striving to regulate this area with a single act. A group of experts has drafted a new long-term care act that would systematically regulate long-term care and introduce a special long-term care insurance¹¹³.

National policy aims to enable older people to stay in their home environment as long as possible. The obligation of adult children and stepchildren to take care of elderly parents is stipulated in the law. The new guidelines of government emphasise pluralisation of services and it is expected that relatives will

¹¹¹ Barkholdt and Lasch 2004

¹¹² 1) EU Commission, MISSOC; Studies on Long Term Care: Poland; 2) Błędowski, Piotr and Pędich, Wojciech (2004)

¹¹³ 1) Ministry of labour, family and social affairs; 2) Hvalič-Touzery, Simona (2004)

still help in family care. The national policy is heading towards further development of the institutional network, formation of day-care centres and centres for home help, from which various forms of home help are managed.

In Slovenia family members offer more care and nursing to older people than institutions and public network programmes.

There is no specific national policy concerning carers. The *Act Amending the Social Security Act* allows for the option that family carers of older people are registered as 'family assistants' and receive financial compensation. They should be previously either unemployed or work part time and care for a seriously disabled person. The *Act* stipulates that the person entitled to institutional care may choose a family assistant instead of all-day institutional care. The family assistant may be a person who has the same permanent address as the disabled person or as one of family members of the disabled person.

Compensation for nursing a close family member, with whom the insured lives in a common household, may be paid for a maximum of 7 days per year (exceptionally 14 days). Additionally, an employee has the right to absence from work without wage compensation (unpaid leave) for up to 30 days in a calendar year, if the absence will not interfere with the working process.

Home care of up to 4 hours a day and up to 20 hours a week is provided locally.

Finland

The situation in Finland is similar to the situation in Denmark. There is a relatively high level of institutional care and service provision by the state enabling carers to pursue a working life.

The shift from institutional to homecare is a rather recent development. Families are expected to take more responsibility for their older members in need of care, but they are also provided with services arranged by municipalities.

Home Care Allowance¹¹⁴ is paid to carers who practice care at home for persons with lowered capacity, sickness, disability or other similar problems. Home care allowance is granted on the basis of a contract between the municipality and the carer. Attached to this contract is a care plan which specifies which services will be provided and by whom, this must be agreed by the municipality, the care recipient and the carer. The Home Care Allowance can be granted in the form of money, services or both.

In 2002 a new Act came into force which obliges municipalities to give round-the-clock carers two free days per month. The municipality must provide substitute care during this leave but can charge a fee for it. The Home Care Allowance recipients are insured for accidents.

The support for informal care is allocated to the carer when a close person is in need of care because of decreased functional ability, illness or handicap. The support for informal care is taxable.

Social and health care services in Finland are based on the principle of universality. There are no separate services for long-term care. Every person in need of social welfare or help is eligible for social and health services.

There is a wide network of support for informal care. The municipality can give support for informal care for relatives who look after an older person, a person with disabilities or a long-term ill person. Support for informal care encompasses necessary services for the client, a compensation for the informal carer as well as leave and support services for the carer. Municipalities provide home

¹¹⁴ Association of Care Giving Relatives and Friends (Omaishoitajat ja Läheiset -Liitto ry; Närståendevårdare och Vänner -Förbundet rf): http://www.omaishoitajat.com/vanhat/english_info.html

nursing, home services and services for the disabled. Short term absenteeism for immediate family reasons, financial compensation not compulsory. There is no upper limit on the allowance, which is taxable. The caregiver who has made an agreement with the municipality is entitled to employment pension accrual with certain limitations. The municipality also covers the caregiver's accident insurance. People receiving support for informal care are entitled to two free days a month. During this statutory free time, the municipality is responsible for providing care to the elderly recipient.

Sweden

It is society's duty to ensure that elderly in need of care or social services receive help of high quality. The contributions made by members of the family should be voluntary and regarded as an adjunct to public initiatives¹¹⁵.

Care of the elderly in Sweden is a public responsibility. In return for taxes, people are provided with a broad spectrum of welfare benefits that guarantee a minimum standard of living, service and care and redistribute income more evenly over lifetime and individuals. Public policies and programmes providing health and social services are comprehensive.

Sweden moved from high levels of institutional care to a policy of enabling elderly to stay as long as possible at home. Thus, public services were reorganised and "home help" is an important instrument of home care - not provided by family members but professionally. Like in Denmark heavy and time consuming care is responsibility of the state, whereas lighter supporting tasks are provided by family members. Hence, strong disadvantages for carers concerning the labour market participation are unlikely as the time spent caring is relatively low.

In January 1998 a new regulation was introduced into the Social Services Act that required social services to reduce the workload of carers who care for their sick, elderly and disabled relatives, through the provision of 'support and relief'. As a consequence, in the 1999–2001 National Plan of Action for the Elderly, central government allocated grants to local municipalities. This money was intended to stimulate new developments for carers (all carers, not just carers of older people). Special attention was directed to the development and support of voluntary sector projects for carers ('Carer 300'). The projects funded through 'Carer 300' were voluntary, demonstration projects; municipalities had to bid for the necessary funding. An evaluation of 'Carer 300' showed that the new projects were slow to get going.

The 1998 Act to Finance Career Interruptions permits employees to take leave for at least half of their regular working hours for between 2 and 6 months and extendable by local labour agreements to 18 months.

Municipal home help services now tend to be targeted on the most frail and isolated older people. However, other public services have expanded considerably, including transport, security alarms and meals-on-wheels; these are all likely to reduce the demands on family carers.

A 1999 national plan to develop the Swedish health care system also highlighted the priority of supporting carers. An agreement between all the municipalities emphasised their responsibility to improve support for carers over the years 2002-2004. Only recently, reflecting acknowledgement of growing numbers of older carers, have support services developed.

The carers allowance is used by municipalities to pay carers for their work. Family carers earn the same amount as formally employed carers and they have similar social security protection. The carers allowance forms part of the health insurance scheme. A working age close relative who takes care of a seriously ill person is entitled to compensation in the form of sickness benefit for up to 30 days (60 in

¹¹⁵ 1) Social Insurance in Sweden - Annual reports (Swedish Social Insurance Agency) <http://www.forsakringskassan.se/>; 2) Johansson, Lennarth (2004)

certain cases) of lost earnings. This is intended to cover terminal and emergency care-giving, not long term informal care, and is restricted to a total of 30 (not necessarily consecutive) days in the lifetime of the person receiving care. The care relief benefit can be paid only if the elderly person receiving care consents to the arrangement. The carers' allowance is given to people below 65 and is taxable. It amounts to 1526 € on average and in 2004 there were 2.002 recipients.

The attendance allowance (65+) is an untaxed cash payment paid by Municipalities to the caree. He can use it to pay the carer for his/her work. The direct cash payment can be made by the municipality if there is a need for home care and the family is willing to serve as care provider. The payment is made to the older person and is used as compensation for the cost of care to the family. The level of payment is based on the number of hours of care needed by the older person. Take-up of this payment is thought to be low. This payment is likely to be received by older carers. Many municipalities have 17 hours of care giving per week as a cut-off criterion. The attendance allowance is not restricted and amounts approx 545 € in 2004. In 2002 it was received by 2,940 men and 2,573 women.

If an older person needs more constant care and attention, a family member can be employed by the municipality as a paid kin care-giver¹¹⁶. It reflects concerns about the poor financial status of daughters who had to stay at home to care for a parent and is used primarily by family members of working age. The salary paid to employed kin care-givers is based on the number of hours of help needed by the older person and is equivalent to the hourly rate of pay received by 'regular' home helps or the lowest rate paid to nursing assistants. The salary is paid by the municipality, is taxable and includes social insurance benefits, such as entitlements to sickness benefit and pension credits. Care receivers pay a home help service fee to the municipality exactly as they would if they were receiving conventional home care services.

In most municipalities, paid kin care-givers have worse terms and conditions than employed home helps and nursing assistants¹¹⁷; for example, they lack rights to time off and holidays, do not receive payments for unsocial working hours and have no job security. Despite this, the salary is widely appreciated by paid kin care-givers, as social recognition of their work as carers. Despite the fact that the government has promoted financial support for carers, the number of relatives paid as care-givers has declined; by 2002, 2,021 people were paid as kin caregivers.

The above measures have to be distinguished from the *assistance allowance* (-65). This allowance is designed to give persons with severe disabilities the financial means to employ a personal assistant. The aim is to provide the most customized support possible, optimizing the individual's influence over the kind of support chosen. The allowance is granted in the form of a certain number of assistant hours that the individual may use over a given period of time. There is no ceiling set for the allowance, the number of hours granted being, in principle, unlimited.

For assistance allowance to be granted, individuals must be in need of help for their daily living for more than 20 hours a week. Personal assistance with basic needs means help with personal hygiene, dressing and undressing, eating, communicating with other persons etc. Personal assistance is defined as a programme of personally designed support to be given in specific situations by a limited number of people." Assistance allowance may not be granted after the age of 65, but people who received the allowance previously may retain it even after their 65th birthday. "

There are no legal measures or special programmes supporting carers who are working. Only the carers allowance ("Care Leave Act") could be considered as such which can be claimed by people in working age to leave work to support a family member in a terminal stage of life (max. 60 days).

¹¹⁶ Support for carers of older people – some intranational and national comparisons: A review of the literature prepared for the Audit Commission, Caroline Glendinning, National Primary Care Research and Development Centre at the University of Manchester; Audit Commission, UK, 2004

¹¹⁷ Support for carers of older people – some intranational and national comparisons: A review of the literature prepared for the Audit Commission, Caroline Glendinning, National Primary Care Research and Development Centre at the University of Manchester; Audit Commission, UK, 2004

Otherwise it is up to negotiations between the employer and the employee, to make the practical arrangement to combine work and care. As a great proportion of women is working part-time already, there are possibilities to care and work at the same time.

In Sweden, the caregiver receives the pension credits he or she would have received in regular employment.

United Kingdom

The Government's aim is to support carers in their caring roles and to help them maintain their own health and well-being. Carers and Disabled Children Act has come into effect and has replaced the Carers (recognition and Services) Act¹¹⁸.

The main form of benefit for caring is Carer's Allowance (CA). Carer's allowance can be claimed by those who spend at least 35 hours a week caring for a person getting Attendance Allowance, or Disability Living Allowance (at the middle or highest rate for personal care), or Constant Attendance Allowance (at or above the normal maximum rate with an Industrial Injuries Disablement Benefit, or basic (full day) rate with a War Disablement Pension).

Local authorities can arrange admission to a care home and temporary respite care. In general, the local authority pays for the accommodation and personal care costs unless the person can afford to pay part or all of the cost. All the direct costs of care from a registered nurse are paid for by the NHS.

The previous measure has to be distinguished from "Direct payments". From April 2003 every local council must offer people who need help to stay in their own home money instead of arranging services for them. These direct payments enable people to choose how they organise the help they need in a flexible way¹¹⁹. Direct payments cannot be used to secure a service from the spouse or civil partner, close relatives or anyone who lives in the same household, unless that person is someone who has been specifically recruited to be a live-in employee.

All employees are entitled to take a reasonable amount of (unpaid) time off to deal with an emergency or unexpected situation involving a dependent.

A major policy objective is to encourage carers to remain in paid work as this enables them to have an independent life, avoid burn-out and help to sustain the caring role. The UK Government places considerable importance on flexible employment practice. The Department for Education and Employment launched the Employers for Work-Life Balance Initiative (aims at encouraging organizations to make a commitment to support carers in the workforce) and the Work-Life Balance

Campaign (aims at raising employers' awareness of the business benefits of introducing policies which help employees obtain a better balance between work and family life). From April 2007, the Work and Families Act 2006 gave certain carers the right to request flexible working such as changing hours or working from home.

4.3 Allowances for carers

Long term care is administrated to people who have reached a stage in life in which they are dependent on others for social, personal and medical needs.

On prior ground, long term care can be provided by three institutions: the family, the market and the State. Historically family has been the main provider. Then progressively, the State, particularly in

¹¹⁸ 1) Department of Health: www.dh.gov.uk ; 2) Nolan, M. et al. (2004).

¹¹⁹ Department of Health: www.dh.gov.uk

Nordic countries, intervened either by expanding its health care systems or by introducing specific programs.

Recent developments focus on a new type of insurance: dependency at old age. In this framework, the carer tends to become an ordinary worker with rights and obligations (work contract).

Belgium

The Flemish Care Insurance provides compensations for non-medical costs for dependent people. When the person is living at home, compensations are provided for family care. People who live at home and are in need of serious care, after obtaining one of the special certificates can get benefits of € 90 for home care per month.

Some local authorities give extra compensations to people caring for a family member at home. The compensations are only awarded if the income of the main carer does not exceed a certain limit and amounts to € 2,47 per day, with a maximum of € 619,73 per year.

Denmark

In accordance with the Consolidation Act on Social Services, persons attached to the labour market who wish to take care of a close relative with substantially and permanently impaired physically or mental function or a serious chronic disease or other illness of long duration at home shall be engaged by the municipal authority under certain conditions. The total employment period cannot exceed 6 months. The family carer becomes official carer, thus family carer benefits do not exist in usual form.

In accordance with this same legislation, persons caring for a close relative wishing to die at home will under certain conditions be eligible for a constant care allowance (1,5 times sick benefit). This is independent of the financial standing of the carer or the family.¹²⁰

Germany

Germany introduced in 1995 a mandatory social insurance scheme for long term care¹²¹. Care facilities include home-care and institutional services. People can choose between cash benefits, in kind benefits or a combination of both. The definition of long term care in Germany is somewhat narrower compared to others countries. However, the program continues to maintain broad popular and political support.

Concerning long-term care insurance, benefits may be taken in cash or in services. The recipient has full control over its disbursement. Recipients of payments can mix informal care and formal services, with the later being provided by a range of agencies. Cash benefits which can be forwarded to informal carers by the caree are lower than the value of professional services.

Around 580,000 of all such family carers are entitled to contributions towards their old age pension and insurance cover in the statutory accident insurance. In order to be eligible for these entitlements the carer must not draw his or her own pension, must care for his or her elder for more than 14 hours a week and cannot be in regular paid employment for more than 30 hours a week. The allowance is partly taxable. Further, respite care, short term car are also available to relieve home carers.

Times of long term care provision are considered for old age pension benefit contribution. Protection without contribution is also provided by the accident insurance. Germany's Long-Term Care

¹²⁰ Leeson 2004

¹²¹ 1) "Long-Term Care Insurance", Federal Ministry of Health. 2) Federal Ministry for Health and Social Security: Third report on the development of long-term care insurance, Bonn 2004; 3) M. Gibson *et al.* (2003).

Insurance System provides for pension credits for each week the benefit is received. Additionally, the pension credits are independent from the employment relationship. If the person is working, the credits are added to the rights generated by his wage. If the carer is working part-time, his/her pension contributions are supplemented in order to achieve the level of a representative worker¹²².

The cash benefit option was intended to encourage and support informal care. The Long-Term Care Insurance has acted as an incentive to increase the capacity of care provided informally; the number of informal care-givers per care-dependent person has increased significantly.

Spain

The Carer's Allowance is a means-tested benefit for carers with very low, or no, income, who live with someone needing full-time care and attention; the latter must be in receipt of one of a number of disability benefits. Allowance is also dependency-level tested. The monthly level of payment was 220 EUR in 2004. Autonomous government provides the allowance.

France

Beneficiaries of the personal autonomy allowance, who live at home, may purchase the services offered by specialist organizations. Beneficiaries may also choose to employ or pay one or several people in their home, in the context of a common law employment contract. It should be noted that the personal autonomy allowance cannot be used to pay for the employment of a beneficiary's spouse, common-law husband or wife, or long-term partner.

Netherlands

In the Netherlands, persons assessed and eligible for non-institutional care, can ask for care in cash ("personal budget for care", PGB) or care offered in kind. Under "the personal budget for care" people may obtain cash instead of services. They must use the money to buy services, but they are free to hire whomever they want. A detailed description is presented in the next part.

A study of the outcome of the *Personal Budget* scheme in the Netherlands found that while care quality is roughly the same as when persons needing care are referred administratively to a designated agency, persons receiving care through a personal budget feel less dependent because they have more control over when care is provided and notably by whom.¹²³

Austria

Austria is unique in providing a "full cash" strategy, i.e. providing an allowance that may be used to purchase formal home care services, pay informal caregivers, or for any purpose. There are no "in-kind" benefits¹²⁴. It is important to note that it covers psychological problems. The Austrian Long-term Care allowance is financed from the general budget.

The Attendance Allowance is paid to dependent persons. It may be used to hire an attendant, including family members, or it may be saved. Attendance allowance is given to a person in a need of 50+ hours of care a month (assistance has to be suspected to be needed for at least six months) or who is on a wheelchair. It is paid from general taxation. There are 7 benefit levels relating to the number of hours of care needed, ranging from 145 € to 1532 € a month. Benefits are not means-tested.

¹²² The Gender Impact of Pension Reform, Department for Work and Pensions.

¹²³ Lundsgaard (2005)

¹²⁴ Federal Ministry for Social Security, Generations and Consumer Protection: The provision of care in Austria, Vienna 2006; and M. Gibson (2003).

Carers allowance is given to carers who care at least 1 year for Long term care allowance recipient (level 4+). It is not taxable. The level of payment is means-tested, and there are 4 benefit levels ranging from 117 to 183 EUR per month.

Poland

Under the Act on Family Benefits, parents of a child who needs long-term care are entitled to a family allowance and supplements to this allowance. Additionally, the child's mother, father or actual guardian is entitled to a nursing benefit due to resignation from employment or other gainful work in connection with the necessity to exercise child care, provided that the child does hold an official statement assessing disability and indicating the necessity of permanent or long-term care or assistance of a third person.

There is no allowance granted directly to the carer for the provision of long term care to dependent people.

Slovenia

A person entitled to institutional care has also the right to choose a family assistant instead. A family assistant is awarded to a disabled person who requires help with performing all of the basic human needs by the locally competent Centre for Social Work. A family assistant is paid by the local municipalities.

Finland

Home Care Allowance¹²⁵ is paid to carers who practice care at home for persons with lowered capacity, sickness, disability or other similar problems. Home care allowance is granted on the basis of a contract between the municipality and the carer. Attached to this contract is a care plan which specifies which services will be provided and by whom, this must be agreed by the municipality, the care recipient and the carer.

The Home Care Allowance can be granted in the form of money, services or both. The minimum care fee is Euro 224, 2 per month. The rate depends on the time and the extent of the assistance required.

In some municipalities it is possible for the carers to receive a higher allowance from approximately Euro 850 up to Euro 1200 per month for giving care the persons who need the institutional care but are cared at home. The highest level is designed to be an alternative for institutional care.

The support for informal care is allocated to the carer when a close person is in need of care because of decreased functional ability, illness or handicap. The support for informal care is taxable. There is a wide network of support for informal care¹²⁶.

Carers supported by HCA are also insured for accidents and have a right to two days off a month.

The impact of this policy is ambiguous as only 22.000 out of an estimated 320.000 carers receive Home care allowance (Pijl and Johansson 2003).

Sweden

¹²⁵ Association of Care Giving Relatives and Friends (Omaishoitajat ja Läheiset -Liitto ry; Närståendevårdare och Vänner -Förbundet rf): http://www.omaishoitajat.com/vanhat/english_info.html

¹²⁶ Ministry of Social Affairs and Health: www.stm.fi

If an older person needs more constant care and attention, a family member can be employed by the municipality as a paid kin care-giver¹²⁷. It reflects concerns about the poor financial status of daughters who had to stay at home to care for a parent and is used primarily by family members of working age. The salary paid to employed kin care-givers is based on the number of hours of help needed by the older person and is equivalent to the hourly rate of pay received by 'regular' home helps or the lowest rate paid to nursing assistants. The salary is paid by the municipality, is taxable and includes social insurance benefits, such as entitlements to sickness benefit and pension credits. Care receivers pay a home help service fee to the municipality exactly as they would if they were receiving conventional home care services.

In most municipalities, paid kin care-givers have worse terms and conditions than employed home helps and nursing assistants¹²⁸; for example, they lack rights to time off and holidays, do not receive payments for unsocial working hours and have no job security. Despite this, the salary is widely appreciated by paid kin care-givers, as social recognition of their work as carers.

Despite the fact that the government has promoted financial support for carers, the number of relatives paid as care-givers has declined; by 2002, 2,021 people were paid as kin caregivers.

United Kingdom

The main form of benefit for caring is Carer's Allowance (CA). Carer's allowance can be claimed by those who spend at least 35 hours a week caring for a person getting Attendance Allowance, or Disability Living Allowance (at the middle or highest rate for personal care), or Constant Attendance Allowance (at or above the normal maximum rate with an Industrial Injuries Disablement Benefit, or basic (full day) rate with a War Disablement Pension).

The Carer's allowance can be paid to more than one person in a household, such as a couple caring for each other. Carers are entitled to claim Carer's allowance if they are: aged 16 or over, earn less than 125 € a week and spending at least 35 hours a week caring for someone entitled to benefits. There are also benefits that can be claimed by carers who work, but the availability of them is means tested.

4.4 Country comparison

The definition of long term care varies across countries, notably the required minimum number of caring hours. . This has a consequence on the support carers are entitled to receive.

When the dependent person is in the policy focus reconciliation of work and care for the carer is only achieved by general flexible working time arrangements adhered in general labour laws. France and Germany are following this way where part time work is a means by which carers are able to reconcile work and care. The Netherlands and Spain focus on the person in need also. However, they grant carers special rights like extra leave in emergencies for care reasons. Austria addresses mainly the dependents but in addition also the carer in their policies. There, carers can reduce their working time due to care obligations and have the right to raise hours again when the caring spell is over.

In Denmark, Sweden and Finland professional services are provided on such a high level that caring is really a choice and not an obligation. Further, working reduced hours is very common anyway which definitely facilitates the combination of work and care.

¹²⁷ Support for carers of older people – some intranational and national comparisons: A review of the literature prepared for the Audit Commission, Caroline Glendinning, National Primary Care Research and Development Centre at the University of Manchester; Audit Commission, UK, 2004

¹²⁸ Support for carers of older people – some intranational and national comparisons: A review of the literature prepared for the Audit Commission, Caroline Glendinning, National Primary Care Research and Development Centre at the University of Manchester; Audit Commission, UK, 2004

Allowances for carers can also have ambiguous effects. On the one hand it can be seen as a fair reimbursement for the time informal carers spend caring. On the other hand it can set incentives to leave the labour market. As with childcare it can be observed that only the availability of flexible working time models and the existence of supporting institutions (respite care, day care facilities) can deliver a combination of work and care.

Reasons for high labour market participation of persons with care obligations in Denmark and Finland can be seen in the general good conditions to reconcile work and family life – becoming manifest in a high level of state funded supporting services - which includes the manageable reconciliation of work and long-term care.

Table III.8: Summary of key national instruments / policies

Country	Policies to support reconciliation work and care	Allowances for carers
Belgium	No systematic policy: special arrangements in the work place.	Dependency insurance (Flanders)
Denmark	Extensive home help enables the combination of work and care.	Caregiver may be engaged by the municipality.
Germany	Dependence insurance is a new pillar. Covers cognitive impairments.	Choice between professional services and informal care. Pension credits if caring for a dependent person.
Spain	Reduction of working hours with reduced pay and unpaid leave.	Carer's Allowance (strict conditions)
France	No systematic policy.	Autonomy allowance may not pay a spouse carer.
Netherlands	Possibility for care leaves and career brake because of care obligations.	Personal budget for elderly. Can pass it on to family carer.
Austria	Complete range of rights (care leave and Social security contributions)	Flexibility in Carers allowance
Poland	No systematic policy.	No allowance for long term carers
Slovenia	Limited measures (Unpaid leave, focus on unemployed or part-time carers).	In certain cases, family assistant is paid by local authorities.
Finland	Different services enable carers to pursue a working life.	Carer receives allowance according to caree's needs.
Sweden	Provision of intensive home care enables the combination of work and care. Pension credits.	Recent measures focus on paid kin carers by the Municipalities.
United Kingdom	Emphasis of work-life balance.	Carers allowance. Pension credits.

In Sweden, Denmark and Finland there is a well-developed system of formal care services for older people, which reduces their need to rely on family carers. Home help services are extensive. Services are organised at local level. This has rendered possible a policy of de-institutionalisation. However, this later policy has reinforced the role of informal carers.

It was noted that in Denmark and Finland overall labour market participation is very high for both carers and non-carers. The difference in labour market participation between carers and non-carers is relatively low also in the UK, Germany, Austria, and the Netherlands. We may note that these countries are also the countries with the more developed services and allowances for long term care.

4.5 Conclusion

The different measures can be summarised as follows¹²⁹:

¹²⁹ The first four correspond to the classification of M. Pijl and L. Johansson (2003).

- Income support. It is generally means-tested and can not be considered as remuneration for the work carers are doing. Benefits of this kind can be found in the UK.
- Recognition of the carer's role. Special allowances for carers are the expression of the appreciation for their work. An example is the Finnish Home Care Allowance.
- Payments equivalent to the wages of workers employed in home care. These are possible in Sweden and Denmark.
- Payments granted to dependent people, but meant for them to pay their carers with. Notably in Germany, The Netherlands, the UK and Sweden. There is a tendency to attach some social security rights to these payments.
- Flexible work arrangements and care leave aiming to maintain the labour force attachment; Generally all countries apply some form of such measures.
- Credits for periods spent out of employment in order to care. Pension credits are the most common. This concerns countries that require a formal relation between the caregiver and the dependent adult but also other countries too (Poland).

Pension credits may be generalised but they might have very different implications. In countries with a high female labour participation, credits may be added to a “normal” work history. In countries with a low female labour participation and short work histories, pension credits might have no impact. The beneficiaries might not have enough years of work and be below the threshold for any contributory benefit.

The ageing of the population requires new ways to finance long-term care. Dependency may be seen as a separate risk where individuals, employers and the State contribute for the financing of this new scheme. Public funds could bring a complement in order to guarantee a minimum quantity and quality of long-term care services to disadvantaged groups.

Finally, the different measures to assist dependent people ought to be neutral in their labour market implications. They ought to avoid distortions leading certain groups into situations with adverse long-term impact (employability or pension levels).

Concerning allowances, benefits should be designed in a way to support women's employability. The different schemes ought to bring an income guarantee but also:

- Avoid isolation from the world of work and favour part time in order to keep links with the labour market;
- Reduce the duration of leaves as they might have negative effects on women's employability and reintegration by the provision of home help;
- Promote sharing family caring responsibilities more equally between women and men. Removing obstacles to men's use of long-term care benefits might be an important step toward greater equality.

The possibility to use a long-term allowance to pay an informal carer may push certain persons into the formal labour market (for example a formal contract is required in the Netherlands) but at the same time it may be an incentive for carers to leave their job. The design of allowances ought to avoid such distortions in the labour market.

PART IV

Examples of best practices that may be transferable across Member States

Introduction

The previous steps have:

- identified the different channels affecting forward looking attitudes,
- quantitative elements for their importance,
- the policies affecting these behaviours and how they aim to affect them, and
- detailed information for a certain number of countries.

Consequently, we have the necessary information in order to pick up the best practices and describe the innovative elements.

IV.1. Health and labour market participation

1.1 Introduction

Part III presented the main policies in the Member States concerning notably senior policy, health management, working conditions, financial incentives and social partners. We present below some interesting cases which have a transnational innovative interest.

Part-time was noted to be one important element of a broader policy. In this section, we will focus on good practice focussing on part-time work per se¹³⁰.

1.2 Examples of best practice: Health and age management

➤ Senior policy

In **Denmark**, the National Market Authority is supporting employers to introduce senior policies at the firm level. This is mainly done by the Senior Policy Consultant Scheme, which finance five hours of consultancy assistance to firms that want to introduce senior policies. Good practices are proposed to firms. For example, systems in which employees can rotate between different task and older workers can be transferred to division where the work is less physically demanding can be organised.

Private enterprises implemented age-oriented personnel policies e.g. the use of flexible part-time employment, assigning tasks with less physical burden to older employees, implementing special training measures for older employees as well as using job-rotation measures. In 2005, the share of enterprises with age oriented personnel policies increased to nearly 45 percent. Especially the positive influences of the qualification of older employees - their know-how and competencies - are recognised by Danish enterprises.

The “Committee on senior Policies” (1997 - 1999) - an early example of age-oriented policy initiatives - initiated among other things a consulting service, which supported the introduction of age-oriented personnel policies in small and medium-size enterprises.

In **Finland**¹³¹, senior policy has a long tradition.

The Finnish Institute of Occupational Health (FIOH) carried out twenty-five pilot studies during 1990-1996. Results to date are very encouraging and demonstrate that poor or moderate work ability can be improved, while good work ability can be maintained. In addition, cost-benefit analysis of some of these pilots has indicated that the financial investments made in developing work ability programs may be returned as much as ten-fold. Moreover, there is also evidence that the life satisfaction of individuals who had participated in a programme has increased significantly.

Since the beginning of the 1990s, Ovako Wire Oy Ab, a steel company, has invested in measures to help enhance the work ability of its employees and to develop practices to retain older employees in work for longer. Most of the measures have been incorporated into the company's normal routine. These include work analyses, ergonomic improvements and redeployments when needed and possible. However, some measures are not as widely implemented as previously. For example, redeployment is now more difficult to implement because tasks have become more defined and specialised. Nevertheless, the Finnish Institute of Occupational Health physiotherapist continues to be responsible

¹³⁰ For our information, we have used the National Ministries and the European Foundation for the Improvement of Living and Working Conditions (<http://www.eurofound.europa.eu/>)

¹³¹ See Finnish Institute of Occupational Health (FIOH): <http://www.ttl.fi/internet/english>

for ergonomics, and the periodic rehabilitation courses for older employees also continue, as do the health examinations and part-time retirement options.

The new shift schedule, which today applies to all workers, lessens the negative effects of three-shift work, especially among older workers and, therefore, enhances their well-being and ability to work. Its effects on workers aged under and over 40 years were examined. Because most of the workers are men, more men than women participated in the programme, although gender was not considered in its design and implementation.

Overall, the new shift schedule led to a decrease in subjective sleep problems and an increase in alertness during morning shifts. The beneficial effects were most obvious during the morning shifts and among the older (44–56 years) workers, who also reported better sleep quality.

The current rate of absence due to sickness, about 5%, is lower than that in other metal-industry companies. Pension costs relating to health problems have also stabilised. The new shift schedule has had no negative effects for the organisation.

In the Finnish food industry company, Saarioinen, comprehensive measures in the field of workplace health and working conditions alongside measures implemented as part of an earlier Senior Programme, were key factors in increasing job satisfaction, extending working careers, and reducing sick leave.

The company has consistently addressed the age challenge for over ten years now. The programme targets blue-collar personnel over the age of 55 who have been with the company for more than five years. Individual developmental discussions and tailored career plans, rehabilitation, physical therapy and fitness measures, training and coaching are at the heart of the programme.

The company has fared quite well in terms of economic performance indicators. A pilot programme (known as the Senior Programme), had a positive impact on sick leave through new work and leisure arrangements.

In **Sweden**, we have two interesting cases: 1) VCT – specific work related reorganizations within the company; and 2) Kronoberg County Council - improving the ability of employees aged over 55 years to stay at work

VCT (Volvo Cars Torslanda) is offering its older employees either transfer within the regular production or substitution of tasks in senior work places. The senior work places are earmarked and gathered under the service unit Special Vehicle Services (SVS). Totally around 370 employees work at a senior work place. The formal demands of access to a senior work place refer to age and/or job tenure. The employee must be 50 years old with job tenure of at least 15 years or must have been employed for at least 25 years in the company irrespective of age.

The fact that SVS has reached profitability is also one reason for the continuation of the initiative. Other important reasons for success at VCT are the fact that the employees involved in the initiative have been motivated and there has been agreement between company and trade unions.

They consider that the initiative will be a success if embedded in human resources management; it contributes to the profitability of the company. One of the future challenges at VCT is likely to be the management's ability to show that the initiative is continuing to be economically sustainable for the company.

Kronoberg County Council's most important responsibility relates to health care, and around 85% of its activity is devoted to medical and health services. The council represents 5,280 employees, 80% of whom are women.

The council introduced an initiative primarily aimed at creating a longstanding work organisation and leadership approach that would improve the work environment and lower rates of sickness absence. It also aimed to increase opportunities for older employees to stay at work longer. Dialogue with the trade unions is cooperative and the unions are involved in initiatives aimed at addressing the future labour supply.

In practical terms, the initiative tried to adopt an age-management approach by improving the ability of employees aged over 55 years to stay at work. The council wanted to create a positive attitude among management in relation to its own and other employees' ageing.

The initiative's most important effect was to create awareness within the council of the issues relating to an ageing workforce and to improve attitudes towards older workers. Evaluations show that participants found the individual discussions with educators to be its most rewarding feature. The initiative also resulted in a more structured approach to strategies designed to retain employees; in addition, it increased opportunities for older workers to share their skills.

Adopted measures include: skills training for managers, using pensioners as substitutes; career planning at 55 years of age to help plan the next 10 to 12 years of their working lives, structured skills-transfer programme called mentorship, enhancing workers' employability – the county council aims to keep all workers' skills up-to-date to preserve their employability, revisions of policy documents regarding the importance of age awareness and person-focused management.

It is too early to say how the initiative has affected the organisation as a whole and if the expected effects, such as a prolonged working life, have been achieved. The council plans to continue its career-planning discussions for workers aged 55 years and, if the results continue to be positive, to extend the measure throughout the organisation.

In the **United Kingdom**, Barchester Healthcare PLC owns several nursing care facilities. It adopts flexible work practices such as shift sharing, staff may move from being care assistants to therapeutic or domiciliary staff as it tends to be less demanding physically, and staff can return to work after retirement age. The outcomes of the measures were positive and they even lowered staff turnover and absenteeism rates. Older workers are recognized to have few periods of short term sickness.

In London and Quadrant Housing Trust, training programmes are monitored to ensure everyone has equal access to new skills and knowledge regardless of age. The organisation had recently launched a programme called "vielife" through which all employees and especially older ones can take regular health checks. They could then receive medical advice, or be referred to a general practitioner in order to tackle common health problems such as dehydration, obesity, stress, insomnia, depression, etc., and flexible working options such as part-time, taking work with lower level of flexibility or full or part-time sabbaticals. By attracting and retaining talent to the organisation, and with a mixture of ages of staff, staff turnover has been reduced by 14 per cent during the last 2 years, and sickness absence is at an all time low.

In the **Netherlands**, the TPG Post has had an age-aware personnel policy since the early 1990s, established as part of the Collective Labour Agreement. A comprehensive approach was initiated to focus on sickness absence, work adjustments and mobility. An age-group approach was initially explicitly present in the relief measures for workers over 55 years of age, but these measures became untenable as government regulations prohibit age discrimination at work. Therefore, the aim is to reduce sickness absenteeism by introducing technological changes, training and a set of rules regulating absenteeism and re-employment.

The Dutch catering company Sodexho¹³² is one leading firms in the contract catering industry. The work is often carried out by women working part-time. The work is physically demanding and growing competition has increased pressures on management and workers. The consequences were high rates of sickness leave and designation as disabled under the Disability Insurance Act. The ageing of the workforce and the increasing financial responsibility which management had to shoulder due to sick leave and inflow into disability arrangements, prompted the company into action. In response to these problems, the company appointed a number of case managers who were given the responsibility of actively solving the problems relating to long-term illness, sick leave and incapacity. Solutions to address the root cause of sickness absence included finding a more suitable job within the company. More generally, internal mobility is a key strategy in the company's approach to age management. Training also covers health-related issues, such as proper posture and the correct use of instruments and machines. To prevent problems, mobility and career development have also received more attention because, in this way, workers become more flexible and get used to change. That the efforts have had positive results is reflected in reduced disability figures.

Another interesting initiative in the Netherlands concerns the Waterland Hospital (approximately 800 employees), the construction company Nelissen van Egteren Bouw BV (approximately 150 staff) and the metal working company Thomassen en Drijver Verblifa (approximately 375 production workers). A common approach to workplace absenteeism emerged from these three cases. It included preventive measures focused on both work and the person itself, and with reintegrative measures to promote the return of the long-term sick.

➤ Disability management

In **Germany**¹³³, the Ford Motor Company is one of the first enterprises in Europe, which has implemented Disability Management. It focuses especially on older employees and employees with light or chronically health problems, with the aim to reintegrate them into the working process. The quality of the Disability Management has been certified based on international recognized standards ("Consensus Based Disability Management Audit").

Since 2003 there is a team composed of a disability manager, a work council, an agent of the management, an agent of the health system and a representative for the severely disabled, working together to coordinate the Disability Management processes. A different team of the management level also coordinates the Disability Management for all European Ford Motor Company-Works

This Disability Management process starts with a longer time or repetitive work incapacity of an employee, trying to strike up a conversation to find out the cause for work incapacity and initiate changing conditions of employment. The aim is to give the employees a chance for life-long working ability and perspectives of work. At all Ford-Works 50% of 500 employees were successfully integrated into the working process by this method. It was the first project ever made at Ford (2001).

Main issue is the focus on the individual resources, not the deficits and networking with different groups within and outside of the Ford Motor Company. Ford sums up that it profits monetarily by this practice.

¹³² AGEING AND EMPLOYMENT: IDENTIFICATION OF GOOD PRACTICE TO INCREASE JOB OPPORTUNITIES AND MAINTAIN OLDER WORKERS IN EMPLOYMENT: FINAL REPORT; Warwick Institute for Employment Research, University of Warwick Economix Research & Consulting, European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities Unit D.2, March 2006

¹³³ HVBG - Hauptverband der gewerblichen Berufsgenossenschaften - Federation of Institutions for Statutory Accident Insurance and Prevention 2007; Ford-Werke GmbH - Ford Motor Company 2006; Zink 2007

To judge about the practice Ford undertakes to react on the demographic change and the older workforce, the following aspects are interesting.

- The idea to prevent longterm illness and early retirement of employees is future-orientated.
- To practice a measure where a team of interdisciplinary staff is trying to match workplace requests and skills of the individual employee makes sense. Especially in big enterprises exist many alternatives for employees to fit in.
- It is obvious, that Ford can afford to hire a special person as Disability Manager, as well as to release further staff to fulfil tasks in this field. This is only possible in big companies.
- Compared to the Operational Integration Management and the Integrations Agreements it is not limited by inner-operational regulations (Biermann 2007).

In Finland, Valmet Järvenpää works is one of the two winner companies of the Finnish Quality Award in 1997. Workplace Health Promotion team coordinates health promotion activities in the plant. Additionally human resource management and occupational health service have their own yearly plans for their activities. Strategies, procedures and statistics about health and health promotion are made available for every one by intranet. Occupational health service surveys work ability indices of all the employees at an interval of five years, starting from the age of 45 years. Early signs of decrease in work ability are used for planning of rehabilitation. Test of physical fitness and risks of cardiovascular diseases are part of these health checks. Occupational health service organise work team health surveys which comprise safety check in working environment and work stress questionnaire.

Plan safety is documented, audited and planned yearly based on the procedures of the safety quality system. Injuries, accidents, sickleaves and disabilities are monitored and data used for planning of health and safety promoting activities. Statistics of occupational accidents and sickleaves are followed. Organisational climate is surveyed regularly. Statistics of company age structure and working hours (standard and overtime) are calculated. A joint committee for planning of physical activities decides every year for those activities suggested to be supported by the company.

A senior policy introduced in the company includes that senior workers are encouraged to continue working and the incidence of early retirement due to disabilities is considerably lower than the average in comparable enterprises. Valmet Järvenpää works have been active in preventing burnout and stress in the work place in starting a information campaign in cooperation with Järvenpää municipality and local parish.

➤ Working conditions

In Germany, the car company, BMW (DE), was committed to achieving an age-balanced workforce when it opened its new plant in Leipzig in May 2005. From the very beginning, the recruitment strategy was governed by a diversity approach which put particular emphasis on a balanced age structure of the future workforce. BMW pursues a strong investment in occupational health measures (OSH) to maintain the work ability of its workforce. This included measures for ergonomic design of working places for blue collar workers, in particular. Particular emphasis was put on preventive measures, e.g. active health care such as back muscle training and the continuous health monitoring of younger workers. There is a systematic assessment of occupational health. Mental capabilities and demands are not assessed in the same systematic way. Regular interviews with employees help to identify problems. Solutions are developed in co-operation with HR management, works councils and occupational health services.

France created the Fund for the improvement of working conditions ((FACT)) which aims to help companies with subventions for:

- Preventive actions against professional's risks
- Actions related to age management taking into account the hardship of work on health of older workers

Reformed in 2005, the FACT is now only available for tiny and middle companies. The FACT has also refocused on age management.

A good practice example in France is the one of the Becquet Company. The company of (vente par correspondance de linge de maison) kept for years the same workers. And now, for the older ones, for less qualified and very hard jobs mental and physical troubles could occur. To prevent this, human resources management of the company worked since 2004 at the working conditions of workers in term of ergonomics. The ergonomics of the work place has improved and older workers' life is facilitated.

➤ Financial incentives

In the **United Kingdom**, the "New deal 50 +", set up in 2000, consists in building individual plans on returning to the labour market for most than 50 years and take into account explicitly the lack of skills or still health problems. Since 2003, the New deal 50 + is offered on a voluntary base to all the beneficiaries of social-security benefits and permit to obtain a generalized tax credit the duration of which is carried in 12 months. English government promotes the improvement of the working conditions of seniors and the development of the working time and considers the problem of non discrimination and variety of the manpower as a condition of increasing employment rate.

In **Spain**, employers are eligible for a 50% or more reduction in social security contributions for employees over the age of 60 who have five years of seniority and are employed on permanent contracts. The reduction increases by 10% per year.

➤ Employers and trade unions

It is important to note that the labour integration of older workers requires a consensual approach between all involved parties. Consequently, approaches to sensitize employers are of a big importance.

Such policies have been implemented in Denmark, Finland and Sweden. Also, in certain countries (e.g. Finland), the employers can be advised by psychologists and ergonomists.

It is important to note that age management may create tensions among social partners inside a company. In a large UK company¹³⁴ in the utility sector, age-related issues linked to the physical nature of certain jobs for engineers and mechanics and coupled with longer working hours have to date been dealt with on an individual basis. At present there are deliberations to develop a flexible retirement strategy that would also help to actively manage the transition of older workers to less physically demanding jobs. These jobs should ideally allow workers to build on their previous experience and could include the mentoring of younger colleagues. However, this strategy has met with resistance from trade unions since such a job transfer could result in employees having to take up lower paid jobs or losing out on substantial pay enhancements. Such job changes also have implications for pension entitlements, particularly if the employee needs to work for more than three years before being able to retire on the occupational pension due to the financial penalties associated with the final salary scheme. Employee representatives would also argue that age should not be a

¹³⁴ AGEING AND EMPLOYMENT: IDENTIFICATION OF GOOD PRACTICE TO INCREASE JOB OPPORTUNITIES AND MAINTAIN OLDER WORKERS IN EMPLOYMENT: FINAL REPORT; Warwick Institute for Employment Research, University of Warwick Economix Research & Consulting, European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities Unit D.2, March 2006

criterion for offering such job transfers as each case should be decided on its merit. A working party, primarily set up to ensure compliance with the impending age legislation, is reviewing a range of employment practices and policies.

1.3 Working time

➤ Income compensation

Belgium¹³⁵ created a Part-time allowance for older unemployed workers. It consists in a complementary indemnity system for certain older employees in case of benefit reduction for part-time work. To benefit from this program, workers must meet some conditions, notably the minimum age of 55 years, be entitled to unemployment benefit and replacement obligation for those hours the beneficiary does no longer work.

In **Finland**, people above 56 years old can choose to work part-time and be compensated for their loss in income. Eligibility to the scheme requires a level of earnings between 35% and 70% of previous full-time earnings, and working hours that correspond to 16-28 hours per week. The system compensates 50% of the income loss due to the reduction in working time and old age pension rights accrue as if the person was working full time at the previous level of earnings.

In the **Netherlands**, the life-span leave (LSL) scheme was introduced in 2004. The LSL scheme is not a collective scheme, but is person-based. It is based on the personal savings of each participant. The scheme includes options to take part-time or full-time leave in all stages of a career. In order to take part in the LSL scheme, an employee has to open a LSL account with a bank or pension fund. Each year one can decide whether to put money into it or not. The employer, as part of the wage package, can also contribute to the account.

In 1999, **Sweden** introduced a new public old-age pension system. From the age of 61 onwards it is possible to work and draw a pension at the same time. The pension can be drawn at 100% or partially in steps at 75%, 50% or 25% and combined with full time or part time work. However, the minimum guaranteed pension benefit cannot, in contrast to the earnings related pension be drawn before the age of 65.

The **United Kingdom** has developed the “New Deal 50 plus” program which offers an Employment Credit to boost pay and an in-work training grant to help boost skills. This program is available for people aged 50 or more who are in receipt of and have been receiving any one or more of the benefits below for at least 6 months: Income Support (IS), Jobseeker's Allowance (JSA), Incapacity Benefit (IB), Severe Disablement Allowance (SDA), Pension Credit., National Insurance credits, Invalid Care Allowance, Bereavement Allowance.

➤ Equal rights

In **Spain**, reforms suppressed certain impediments to part-time work. The most recent legislation equalised pension rights of part-timers with those of their full-time counterparts.

In **Italy**, a new law (2003) aims at defining new rules to give sufficient protection to part-time workers, and encouraging part time work. Reduced social contributions may be granted for part time contracts with workers from disadvantage categories like older workers in unemployment or disability benefits.

In the **Netherlands**, the Equal Treatment (Working Hours) Act (1996) prohibits an employer from discriminating between full-time and part-time employees, unless there is an objective justification for

¹³⁵ Dick Moraal / Gudrun Schönfeld op. cit.

doing so. The underlying principle of the Act is that part-time work is equivalent to full-time work. Permanent and other employees should not face uncertainty about their legal status or experience discrimination on the basis of their working hours. It is also unlawful to discriminate between part-timers who work more or fewer hours. A part-time worker is proportionally entitled to the same pay, the same bonuses and the same number of days' holiday. This also applies to pension rights¹³⁶.

➤ Collective agreements

Denmark has stressed the conclusion of special chapters covering older workers in collective agreements. There is a possibility to deviate from collective agreements and establish flexible work time arrangements for older workers. A good practice coming from Denmark is, for example, the one taken by Netto (which is one of the largest Danish supermarket chains). The company has been very active in creating ways of retaining and attracting older employees. In these supermarkets, there is a greater degree of part-time work and special arrangements, but sick leave costs are much lower.

In **Germany**¹³⁷, smooth transition to retirement is possible through the old-age part-time employment act. In practice, many collective agreements, especially in some larger sectors (including many industries where the hardship of work often leads to health problems for workers), contain regulations that are more beneficial, thereby encouraging employees to take up old-age part-time work contracts.

In **France**, some sectors with hard working conditions and workers in bad health, like steel industry for example, part-time retirement is proposed instead of early retirement. But in general, a phased retirement scheme is possible in France for all workers but under certain conditions.

In the case of the French mail-order company, Blanche Porte, which is a medium-sized enterprise, a collective agreement has been signed with the trade unions on part-time working for workers aged 50 years and over. These employees could choose to work part-time by earning lower wages, while the company continues to pay the full retirement contribution. This agreement is renegotiated every year by trade unions and the management. In general, trade unions in the enterprise are prepared to negotiate these issues and seek to find solutions.

➤ Life time balance

In **Austria**, a policy aims to favour a balance between work and private life. Human resource management of each company is advised on what basis and how to go about organising the work rhythm of older workers, taking into account the different commitments, strengths and weakness of older workers. *Polyfelt*, for example, is a company with a relatively high proportion of older workers. As night shifts are a major stress factor especially for older workers, new shift work plan was drawn up in 2000 that took account of the wishes and problems of the employees. By 2003, health status of older workers in this company had improved.

1.4 Conclusions

By summarising, we may note the following innovative axes:

1. Developing diseases prevention and Health Education; Policy emphasis is necessary to prevent as much as possible the onset of chronic diseases and disabilities among older workers.

¹³⁶ "Part time work in Europe", European Foundation for the Improvement of Living and Working conditions Report available in electronic format only. website: www.eurofound.eu.int

¹³⁷ Dick Moraal / Gudrun Schönfeld op. cit.

2. Improving working conditions in the companies exerts an impact on health and thus on the labour supply.
3. The integration or the rehabilitation of people with chronic illness or disability on the labour market through individualized (adaptation of jobs) and flexible devices (e.g. working time).
4. The responsabilisation of the companies and the elaboration of consensual approaches.
5. Reallocation of tasks: assigning older workers with health problems to less physically demanding tasks, shorter working hours and ergonomic adaptations.
6. Health promotion and regular health checks.
7. Consensus between social partners.
8. Skills training for managers and career planning.
9. Technical assistance to SMEs.
10. Financial support to companies.

Available evaluations indicate that such initiatives are profitable to companies. Results to date are very encouraging and demonstrate that poor or moderate work ability can be improved, while good work ability can be maintained. In certain cases, they lowered absenteeism.

Part-time might be an interesting solution for people with health problems. Helping workers in bad health by adjusting their working time to their working capacity may avoid some early retirement. Identified practices cover:

1. Law adaptations in order to guarantee equal rights for part-time workers,
2. Equal treatment and no discriminating between full-time and part-time employees,
3. Negotiated procedures through collective agreements,
4. Compensation for income loss.

IV.2. Financial (dis) incentives

Generally, the Member States have tried to rise the effective retirement age through different channels, notably: abolition of early retirement schemes, rising the retirement age, making the retirement age flexible and penalising early retirement.

However, there is not a general agreement that rising the earliest eligibility age is an efficient solution. Opponents claim that many individuals can neither work longer nor save more for retirement. Raising the earliest eligibility age could impoverish these groups as well as strain social programs like disability benefits that would likely end up serving more people. Finally, they contend that withholding benefits until a later age hurts those with shorter life expectancies, and shifts more retirement wealth to those with longer lives¹³⁸.

Withholding Social Security benefits until age 65 would hurt those with shorter life expectancies, and these people tend to be low skilled males. Any increase ought to take into account work penibility and life expectancy. Furthermore, a higher legal retirement age might result in a decline of old age pension as an incentive to work longer. This will further discriminate against low skilled manual workers.

2.1 Introduction

A certain number of financial measures may act as incentives or disincentives for work and social participation. In this chapter, we will focus on financial measures which concern benefits such as sickness, disability and old-age pensions. Financial incentives or barriers concerning voluntary work are treated in the relevant chapter.

2.2 Best practices

In the following, we will focus on countries which managed to conjugate employment policy and health promotion to increase the employment rate of seniors and implement active and healthy ageing policies.

We can observe two types of countries:

1. Those who have a structural high employment rate (Denmark and the United Kingdom for example),
2. Those whose increase of the employment rate of seniors was very high (Finland and Netherlands for example).

➤ Incentives to postpone retirement

In **Denmark**, a reform encouraged the workers to delay their retirement departure by granting advantages to those who stop their professional activity later and by punishing the rights of those who withdraw prematurely from the labour market. Without focusing explicitly on handicapped population, these measures actually also encourage the persons in poor health to work more.

Another important reform covered the Anticipatory Pension Scheme. The target group for anticipatory pension is persons in the age group 18-64 whose earning capacity is permanently reduced. An important criterion is the degree to which a person's vocational ability is permanently reduced. One of

¹³⁸ A. Munnell (2006)

the basic aims of the reform is to make social policy more active i.e. to give a higher priority to “active solutions” rather than “passive income transfers”. A general objective in a number of changes in social legislation in recent years has been to increase employment and reduce the number of persons on passive income transfer e.g. anticipatory pension.

In the old legislation and practice a person’s lack of vocational ability (degree of loss of earning ability) was the basis for decisions on awarding anticipatory pension. The focus was on a persons’ deficiencies, illnesses, and incapacities i.e. what a person is not able to do. In the future the focus will be on the persons’ “working ability”. The general idea is that all possible types of active measures (e.g. also work rehabilitation aiming at a flexjob) should be tried before anticipatory pension (passive income transfer) is awarded.

Compared to present legislation an important change is that a persons’ “working ability” is not only considered in relation to ordinary employment but also in relation to publicly supported employment (in particular flexjobs) and employment according to social chapters where the job-requirements are lower. Therefore it is expected that the reform will result in a reduced inflow into anticipatory pension and an increased inflow into flexjobs. A successful implementation of the reform presupposes that the local authorities are in fact able to find a sufficient number of flexjobs in private and/or public enterprises. Therefore, full implementation of the reform assumes that public and private enterprises are willing to establish those kind of new jobs as legislation does not require or force them to do so. Thus the reform of anticipatory pension is intended to promote an inclusive labour market.

The reform of anticipatory pension also implies other important changes. The anticipatory pension level (for a single person) will correspond to unemployment benefit.

➤ Decreasing sickness costs

In the **Netherlands**, the Work Handicapped Reintegration Act (REA) has several interesting financial incentives. Any employer who employs a disabled worker or who assigns him to a more suitable position within his company can receive a considerable compensation to finance all costs this may involve. It is under this Act also possible to grant disabled worker facilities which tend to maintain, restore or improve his incapacity for work

Many people derive eligibility for REA from their eligibility under other measures (passporting). These include, notably:

1. recipients of a disability benefit;
2. people using a provision aimed at maintaining or recovering work capacity;
3. people whose disability benefit terminated no longer than five years ago.

REA provides a general frame for increasing the labour market participation of people with a ‘work handicap’. It places the general responsibility for integrating disabled people on employers and unions.

REA introduces some financial incentives, including:

- employers are offered a fixed budget for every disabled person they take on (in principle to finance adaptations);
- sick pay for disabled people is met from the national sickness fund, rather than by the employer;
- disability insurance contributions are reduced if 5%+ of the payroll is to people with disabilities;
- a personal budget has been introduced for disabled people entering employment.

One important way to increase the employment of older workers is to reduce the cost of hiring older people with fragile health. The most common proposal is to eliminate employers’ expenses related to

health for those 60 and over. This would relieve companies of a substantial expense. Before hiring a person, the employer may face a dilemma between a young and an older person. The sickness probability of the older worker is generally higher and consequently the cost for the employer is higher. This health gap might be compensated by reduced employers' contributions. REA is interesting from this point of view. Of course, the sickness insurance (or part of it) has to be paid by alternative sources (e.g. public social security). This ought to guarantee the same rights to the particular worker as those enjoyed by other workers.

In order to avoid age discrimination, this measure might concern only hiring of new workers and the not sickness cost of already employed persons. For example, in **Finland**, the employer pays full salary for the first 9 days if the employment relationship has lasted at least one month. If the employment relationship is under one month, he pays 50 % of the salary. For the employer, this means a lower insurance cost. Of course, the particular worker is treated as other workers, in terms of sickness benefits.

➤ Incentives to work

Generally, a sick person after a certain period of time may receive a temporary disability benefit and if the situation is permanent, he might gain a disability pension.

The question is whether the beneficiary may accept a job and what are the implications for the granting of the benefit. In fact, the argument is that if the beneficiary accepts a job he may lose his benefit. In this case, it is not sure that he will recover his pension if he is not successful with his new job. Consequently, he will be discouraged to undertake a job search.

Consequently, a solution might be the possibility to cumulate an invalidity pension and earnings from work. Accumulation is possible in several countries. However, in certain countries accepting a job might be a very risky initiative. It is thus desirable to eradicate extreme cases and allow accumulation at least for a minimum period. Also, in case of loss of the job, the beneficiary ought to recover his pension without undertaking a new long process of administrative recognition.

In **Sweden**, sickness compensation may be granted to people who for medical reasons have a working capacity reduced by at least 25% for a period of at least one year. If the person receives sickness or activity compensation, he/she has the possibility to work without losing entitlement to compensation. This is called dormant sickness/activity compensation. When sickness/activity compensation is paid for at least a year and the person wants to try to see whether he/she can cope with working, the person can apply for a trial period in which he/she receives compensation and pay at the same time. If the trial is successful, the person can apply to have his/her compensation made dormant. The trial period and the period of dormant compensation may together last for up to 24 months or for the remaining period for which the person has been granted compensation.

Similarly, in the **United-Kingdom**, the government has modified the social security rules for disabled people on long-term incapacity benefits. The purpose of the reform was to make it easier for them to take up employment by guaranteeing that if their job does not work out because of their illness or disability, they will be able to return to their previous level of benefit up to a year later. In April 1999 further changes were made to the benefit rules to help people with disabilities back to work. They include allowing those on incapacity benefits to earn a small amount of money and to take trial periods in jobs without losing the benefit. Also, Belgium allows cumulating income from work while drawing a social security invalidity pension.

In the **UK**, the Working Tax Credit (WTC) is for people who are employed/self-employed who usually work more than 16 hours/week, are paid for that work and expect to work for at least 4 weeks. To qualify for the disabled element of the credit, people must be aged over 16 and have a mental or

physical disability that puts them at a disadvantage of getting a job. This disability must be verified by a healthcare professional and the mental or physical impairment must make it difficult to get employment.

This scheme can be cumulated with other disability benefits. In fact, one of the qualifiers for the credit is that the candidate receives already a benefit related to his disability. The scheme is restricted to those in employment for more than 16 hours/week. The amount of tax credit received depends on annual income and the number of dependent children.

In **Finland**, a tax deduction based on the degree of disability is allocated to a large number of people. The tax deduction based on degree of disability is meant for persons who have a permanent disability arising from an illness, impairment or disability. It is a tax deduction on earned income, and the degree of disability must be at least 30%.

The amount of deduction depends on the degree of illness or disability. If a candidate applies for the invalid's tax deduction, he has to attach to the application a medical certificate showing the permanent degree of disability. From this point onwards the tax deduction is made automatically by the tax authorities. If the degree of disability changes the beneficiary should notify the tax authorities.

The full disability deduction is granted for those with 100 % degree of disability. Otherwise, the disability deduction amounts to a percentage of full deduction equal to the degree of disability. Correspondingly, the degree of disability of a person receiving a partial disability pension is defined as 50 %. The right to a disability deduction as determined by the disability pension remains after the disability pension is replaced by the old age pension. Disability deduction can be applied retroactively for five preceding years.

➤ Actuarial fairness

There are two contrasting reform models: the Swedish and Italian models which are dispensing with the criterion of age in favour of a more flexible system based on an actuarial approach, and the German, English or French models which involve structural adjustments, particularly with regard to raising the age of retirement.

Reforms aiming to extend the period of contributions required to be eligible for retirement on a full pension were undertaken in several countries (e.g. France, Germany, UK). The number of beneficiaries of public sector mechanisms for early retirement has been declining since in several countries (e.g. France, Germany, and the UK).

Increasing legal retirement age put at serious disadvantage older workers with health problems. The question is whether reforms based on actuarial principles are more fair solutions.

Several countries recently introduced reforms aiming to promote actuarial fairness. An interesting reform which was introduced notably in **Sweden** and **Italy** concerns old-age pension. In what is called the Notionally Defined Contributions (NDC) system, pension benefit is based on paid contributions.

Sweden and Italy thus deeply modified the access rules to the retirement removing the concept of age to the profit of a progressive retirement based on actuarial fairness. In Sweden, starting from the 61 years age and without limitation of age then, it is possible to liquidate its pension benefits according to an actuarial rule depending on the life expectancy at the moment of the liquidation of the rights. In Italy, a similar rule is introduced making it possible to liquidate its pension benefits between 57 and 65 years. These measures could allow taking into account life expectancy and the progressivity of replacement rates. From this perspective, NDC scheme gives more flexibility than traditional defined benefit pension schemes. Additionally, any contributions paid to the system, could be used to recalculate the pension, taking into account contributions paid after retirement.

Pensions can also be granted on a partial basis. Persons may decide to draw pensions based on the portion (for example 50 per cent) of their account for some period of time and continue working (on full or part-time basis). From this perspective, NDC scheme gives more flexibility than traditional, defined benefit pension schemes. Statutory retirement age defines the end of active life on the labour market and may thus have an impact on labour market behaviour (less effort by the worker to find a job and fewer efforts by companies to hire and train older workers). On the other hand, an increase of statutory retirement age might increase unemployment or disability pensioners at the end of work life.

The important point is “life expectancy” as it enters into the method of calculation. If life expectancy is calculated on the basis of date of birth, the system might be disadvantaging for people with health problems. In fact, it implies a transfer of resources from unhealthy to healthy people. On the contrary, if life expectancy takes into account the history of the nature of work and notably work penibility, then the system might gain some additional actuarial fairness.

2.3 Conclusions

Innovative measures have focussed on:

- Decrease the health cost of employers when they hire older workers with health problems,
- Focus on work ability rather than work incapacity,
- Allow accumulation of invalidity pensions with income from work for a specified time period,
- Decrease the implicit tax on any continuation of activity by providing tax credits to disability pensioners desiring to work, and
- Actuarial fairness.

Several reforms highlighted the need to treat disability pensions, early retirement and old-age pension simultaneously.

IV.3. Active ageing

3.1 Introduction

As noted in Part III, countries often focus on different aspects of active ageing such as physical activity, social integration, education and volunteering.

Several programmes are organised at a regional or local level in cooperation with the informal sector. The advantage of such initiatives is the proximity with the client.

Proximity with clients favours the diffusion of healthy lifestyles and education among disadvantaged groups. These groups ought to be the priority groups as often they cumulate unhealthy lifestyles and poor economic conditions.

3.2 Best practice: Activity and participation

Most of the Member States (e.g. Belgium, Spain, etc.) promote **day-centres** for seniors where they can participate in activities with others seniors. This is a good way to improve activity of seniors because it is often free. Seniors can achieve task and feel part of a group. It creates a social network which leads to more activity for seniors. These interactions are good against the decline of cognitive reserve. But we have to mention that these programs only work if these centres are close to the home of seniors. In deed seniors have often mobility restrictions. Also, they don't feel secure, they feel lost if they are too far from home, and they often don't have any means of transport. So these day-centres for seniors seem interesting but their location have to be studied in detailed for accessibility reasons.

A good practice coming from **Austria** is the Empowerment Plan 60 aims at greater participation and empowerment of older people through community-based interventions. Funded by the Austrian Health Promotion Foundation and carried out by the Research Institute of the Viennese Red Cross, it aims at promoting structures that enable the elderly to be an active independent and assertive part of society. It targets people aged 60-75 in urban settings. Building up social networks is also an important component of the project. The preliminary evaluation shows significant changes in a relatively short timeframe. Similar intervention in Styria (AT) covered exercise, communication and memory practice.

In Austria, every federal province has its own health promoting institute (regional working groups of preventive medicine), most of them offering diabetes, stroke, nutrition, heart disease or exercise counselling and workshops. Some have "healthy communities" and "healthy villages" with activities, lectures, and seminars for different groups, promoting a healthier life style. More innovative areas include preventing colon cancer, PSA (prostate specific antigen) or Tbc screening and awareness programs.

In **Spain**, the social centres for seniors are gerontology facilities opened to the community that promote active ageing, facilitating personal development, the coexistence and social participation. Objectives of such centres are to promote healthy lifestyles and positive attitudes towards ageing; to drive active social participation and integration of older persons in the community; to improve qualification and self-determination of older persons; to drive and dynamise social relations; to facilitate access to culture, lifelong education and use of the new technologies; to improve social image of older persons by offering positive and not stereotyped models of aging.

In those centres, the elderly can develop participation skills and can join voluntary programs and generation interchange programs. All these programs keep the elderly active in their region. To join

this program they have to contact the Municipal Centre of Social Services located in the zone where the participant resides.

In Sweden, the National action plan on policy for the elderly focuses on active living, meaning secure, independent, respect and access to services. It notes that health promotion for older people should be developed by preventive home visits by the home-help services and by general health promotion.

Some results have shown that more than seventy different non governmental and governmental organisations have been collaborating during the launch year. Over 80 national conferences have been arranged, the first national conference of health enhancing physical activity had over 900 participants.

A total of 205 (out of 289) municipalities were familiar with the physical activity year and 65% had planned their own activities. Over 200 companies, with 50 000 employees all together, are involved in a certification process of becoming a health promotion company. Nearly 3000 mass media features on the physical activity year has been spotted during the SoM-year as well as news on how to be physical.

Over 20 official publications have been produced and distributed to different target groups. National recommendation for health enhancing physical activity has been set - "At least 30 minutes of physical activity per day on a moderate intensity". Physical activity has become one of the most important public health issues. This year's good results have led to a new commission from the Government - "Keep Sweden Moving". – The commission instructs the National Institute of Public Health to continue their work with health enhancing physical activity throughout year 2003 and 2004. The Commission also includes a request for a proposed national strategy for increased physical activity in society.

In **Germany**, joint Trade Union for the Services Industries, part of DGB (Vereinte Dienstleistungsgewerkschaft) pursue the aim of improving the communication capabilities of the elderly through Senioren OnLine, the instalment of Internet cafés for seniors and the ver.di Internet-Senioren-Club, a communication and discussion platform with Internet training offers. For example, EuCoNet (European Computer Network) is a best practice project launched in Germany in partnership with other EU countries. In this learning partnership called EuCoNet (European Computer Network) the target group - older people from Italy, Czech Republic, Slovakia, Germany and Scotland - play an active role by reflecting on their cultural experience of the opening up of the Internet. They exchange and compare differences and review the possibility of applying what is best from each country. Multiplier networks, development of Internet Cafés for older people and the development of learning material for this target group have all made substantial contributions to advancement. For example teaching internet for seniors is organised. Because most of the participants have no previous experience with computers and they are afraid to use a computer, teachers are trying to motivate them as much as possible. Courses starts with WWW search continue with writing letters, using E-mail and they also create their own web pages. At the end of course they have public presentation of projects which they prepare. There are only 15-20 students in a class, all the courses occur in the daytime and there are 4 to 5 courses a week. There is only one student per computer in each class. Everything is explained carefully and patiently like this nobody falls behind. Lectors provide high level quality instruction to give the seniors knowledge, understanding, experience, and ability to use computer. Older adults often have difficulty in seeing and hearing so the teacher must speak in a voice loud enough for everyone to hear clearly, articulate carefully, and do not speak too rapidly.

In **Poland**, there are quite a lot of different kinds of small programmes and initiatives for old persons, which are organised by mainly non-governmental organisations. In general, these programmes mostly aim to:

- activate seniors through the work in artistic- musical or hand-made groups,
- developing different kind of art skills of old persons,
- organisation of free time for seniors (trips, theatre, cinema, museums),

- education on health care,
- Activating seniors for help and assistance for other seniors.

An example of a program for older persons is a special ‘Voivodship Programme of Social Policy and Social Assistance against Ageing for the years 2003 – 2005’ undertaken by the Malopolska Voivodship and the Regional Office of Social Policy. The overall aim is: to limit old persons’ problems and promote social inclusion.

The **British** Department of Health commissioned “Moving More Often”, a three-year project. This project was aiming at promoting regular physical activity and independence for older people in the transitional phase and frail elderly people. The “Up for Owt programme” in the UK was a community physical activity project launched in 2002. The programme was aiming to coordinate exercise classes run by different agencies and also to target older people not already cared for – those who find it difficult to get out of the house. Other active ageing programs in the UK included:

- The National Coalition for Active Ageing (April 2006): It was formed to promote physical activity with older people, abilities to increase their health and standard of living in older age.
- The Citizenship policy statement (April 2006): Help the Aged is working towards tackling age discrimination in all aspects of life and increasing older people's participation in the community.
- The Citizenship (September 2004): It aims to help voter participation, community life, volunteer efforts and older people's contributions to their communities.

In **Germany**, the Family Ministry stands out with two projects: the instalment of Seniorenbüros (Senior Citizen Bureaus) which serve as a point of information for older people who wish to do voluntary work, and the multiplier programme “Erfahrungswissen für Initiativen” (Practical knowledge for self-organised initiatives) – educating older people as ‘Senior Trainers’ who will then spread practical knowledge to self-organised initiatives and educate other volunteers.

In the **United Kingdom**, the National Coalition for Active Ageing has been established to bring together key agencies and stakeholders to act as a collective voice and champion the cause of promoting physical activity with older people of all interests, abilities and ages.

The **Finnish** “Health 2015” programme notes that in setting the targets and working out the lines of action for the programme, the aim was to get as close as possible to the everyday environment in which people live and work. That is why individual people, the local level and its actors, the social welfare and health care system, other local service systems and NGOs, business and industry, and culture are expected to play an important part in implementing the programme and achieving its goals.

The Finnish National Healthy Cities Network Action Plan 2005 to 2008 aims to promote welfare and health among the population and prevent ill health. To this end, the Network develops strategic management, activities and activity evaluation in welfare and health issues in the participating municipalities, and produces and passes on experience-based knowledge about the possibilities, tools and working methods of welfare and health promotion between municipalities and sub-regions, nationally and also internationally through the WHO Network of European Healthy Cities Networks. The Network bases its activities on the targets specified in the Health 2015 public health programme.

Work on human impact assessment has gradually been started in the participating municipalities. During this term of operation, the emphasis is placed on incorporating prospective assessment in municipal decision-making. The senior elected officials of the participating municipalities are expected to ensure that social and health impact assessment forms part of major decision-making processes of the municipal council and committees. For example, the assessment may concern the impacts of an intervention/a plan on socio-economic health inequalities in the municipality. The aim is to promote local competence in prospective impact assessment methods. The participating

municipalities can later act as local experts in training events on impact assessment and in other municipalities' pilot projects¹³⁹.

In France, in February 2005 the government launched the 'plan for health at work 2005-2009' (*Plan santé au travail 2005-2009*). This plan aims at "improving the prevention of occupational hazards". Its budget for 2005 amounts to 10 million euros. This plan includes 23 measures and is articulated around 4 top priorities:

1. improving our knowledge of dangers, risks and disease exposures at work;
2. Reinforcing the efficiency and effectiveness of inspections aiming at assessing compliance with labour standards;
3. Reshaping dialogue authorities providing expertise on occupational hazards and health at work;
4. Encouraging private companies to be proactive in this field.

3.3 Best practice: Volunteer work and health

One mean to enhance activity and participation of the senior citizens is a voluntary work. In order to enhance functional ability, health and well-being of the volunteers, it is important that voluntary work fulfils the following requirements; It should be based on a free choice, give possibilities to utilize one's talents and participate in a meaningful way in society. Furthermore, volunteering should not be too time-consuming and binding. Incidentally, customers have been satisfied with the older volunteers. Particularly, voluntary work that involves visits to older clients, such as work of 'friend visitors' and 'support persons', have been found to be beneficial to the clients; Old volunteers are competent and likely to continue their job – that also is positive for the clients and for the voluntary organisations. Consequently, it is important to promote volunteering of the senior citizens. This may help their own health, self-esteem, well-being and social inclusion as well as the health of those receiving the services.

"Friend visitor" and "support person" activities, in many countries organized, for instance, by Red Cross or congregations, could be called as an example of the 'functional or best practice'. Next we shall present some volunteer projects in various countries that include functional practices and that may be applicable in other countries as well.

In Belgium¹⁴⁰, the *Training for Senior Citizens' Consultant* programme recognises and valorises the skills and abilities of senior citizens. The training actively contributes to the ability of older citizens to live their life according to their own wishes as long as possible. In training senior citizens are approached in their daily life situations and as citizens with economic and cultural rights and duties. The emphasis lies on supporting the formal and informal integration of senior citizens, both of those who need assistance, and of those who are making a significant contribution to society. This support is not limited to specific situations but is a continuous, dynamic and lifelong process. The training seeks to translate supporting principles flexibly in divergent situations.

In Germany¹⁴¹, "Experience for Initiatives" (EFI) is an important step in activating older generation taking part in voluntary work: around 1,000 older people have already taken part in courses to be *senior* trainers in order to learn something new and to use their experience in many local projects – for the benefit of all age and population groups locally. "*Senior* expertise teams" become reliable partners and important pace setters for voluntary involvement in local communities. Active *senior* citizens develop creativity, innovation and a willingness to act. They are putting the cycle of give and take between the generations back in motion and, at the same time, are drawing a new picture of old age.

¹³⁹ Text approved at the Pori Network Meeting on 29 November 2005; <http://info.stakes.fi/>

¹⁴⁰ Voluntary Action in Belgium - Facts and Figures. European Volunteer Centre

¹⁴¹ Voluntary Action in Germany - Facts and Figures. European Volunteer Centre

Similarly, in **Germany**, “*Senior trainers*” get involved in many ways: whether it is a matter of organising international aid transport, designing PC courses or project to support neighbourhood management in local authorities – “*senior trainers*” are active everywhere and they pass on their expertise and experience to others. The spectrum of involvement ranges from activities in the social sphere right up to innovative project ideas in culture or politics. The concept for the use of the experience of older people is aimed at older people who are not (only) involved in traditional voluntary work, but who want to contribute their expertise and skills flexibly, shape their involvement for themselves and act as multipliers. “*Senior trainers*” want to help to correct outdated images of old age and to redefine the role of older people in society.

The diversity of the involvement of the “*senior trainers*” has resulted in four roles of responsibility in which older people contribute their knowledge gained through experience in community life as “*senior trainers*”: supporters and counsellors, initiators of new projects, networkers in community life, team coordinators, moderators (<http://www.efi-programm.de>)

In the **Netherlands**, the SESAM Academy¹⁴² stands for Academy for Seniors and Society. Within the Academy retired upper (business) managers can follow a training course and become a voluntary consultant for non-profit organisations. The training course encompasses study days, days of homework and 40 hours field practice. After the course they become SESAM consultant – on a voluntary base - in all kind of non-profit organisations, mostly on a project base, and always on their request, for a period varying from one to 50 days. The aim of their support is to improve the quality and effectiveness of the organisation¹⁴³.

Some 90 Dutch local authorities run ‘guild projects’ (Gilden) through which older people offer their life experience and talents to those who are interested to benefit from it. The Zeist Guild offers for instance supplementary support to children with learning difficulties and gives conversation lessons to refugees.

In 1999, a three-year national incentive programme was initiated aiming to develop intergenerational activities at neighbourhood level. Through such activities people from different generations meet in order to learn from each other, help each other, or to work towards achieving a common goal relevant to their community. At national level, the Netherlands Institute for Care and Welfare (NIZW) supports these efforts through a website, manuals, training modules for professionals and volunteer workers (e.g. on conflict resolution, participation), and by organizing project visits and study trips. NIZW programmes interconnect to similar initiatives of the European ‘Generations in Action’ network. (Factsheet, Senior Citizens in the Netherlands).

In **Finland**, we may note the three following examples:

1) *Substitute grandparents*¹⁴⁴

A non-governmental organization Talkoorengas in Kerava, Finland arranges a service called substitute grandparenting. A substitute grandfather or grandmother can offer closeness and intimacy for children that do not have a grandfather or a grandmother of their own or are living far away from them/he/she. The Service is also available for families whose parents are working long hours or need support because of illness, economical problems or single parenthood. Substitute grandparents can bond with a child and support the whole family through bridging generational gaps and transposing cultural inheritance.

2) *Loppukiri (“Final Sprint”)*¹⁴⁵

¹⁴² Factsheet, Senior Citizens in the Netherlands

¹⁴³ <http://www.sesamacademie.nl/>

¹⁴⁴ <http://www.talkoorengas.fi/varamummojapappa.htm>

¹⁴⁵ Mokka & Neuvonen, 2006. <http://aktiivisetseiniorit.fi/>

Loppukiri (“final sprint”) is a building completed in 2006 based on peer-help and ageing together. The housing block contains 74 flats with at least one over 48 years old living in each one of them. The inhabitants are committed to cooking together and cleaning common facilities. Participating in common tasks gives the inhabitants a feeling of security in their everyday life. They feel that neighbourly help is a much better option than depending on public services or on relatives for help in their ageing-related needs and problems. The inhabitants are strongly committed to communality, are actively involved in all tasks and hence are willing to make their old age qualitatively better.

3) Hospital volunteers¹⁴⁶

Talkoorengas in Kerava, Finland has since 1993 been organising a program of voluntary work in hospitals. The Volunteers visit two wards in the municipal health centre in Kerava and provide care that basically anyone could provide. In this sense, they are not there to replace the hospital staff or carry out their professional duties, but working alongside them. The wards have mainly bed patients with chronic diseases that are in many ways, especially physically, dependent on their helpers. The volunteers visit the ward approximately once per week a few hours at the time and they see one or more patients during their visit. The activities may include talking with the patients, listening to them or reading to him/her, sometimes even feeding and promenading – depending on the condition of the patient. Most of the volunteers are over 50 years old and retired.

In the **United Kingdom**, we may note the *The GIA (Generations in Action) Programme*. The main aim of the GIA programme was to enable older people to engage in helping younger members of the community through the use of mentoring and other one-to-one activities. The programme was later expanded and now GIA programme operates in many areas of England in addition to Salford core programme. The main aim of the programme encourages the transfer of skills and experiences of older people to younger people who are identified as needing extra support. The key features include for instance the promotion of volunteering by older people (aged 50+), a focus on mentoring as a form of volunteering activity, promoting the value of volunteering in terms of benefits to health and well-being, community engagement, social inclusion and community action for older people and seeking to increase the number of older people engaged in volunteering in their community.

According to Evaluation Report (Ellis 2004) all older volunteers of the GIA programme enjoyed a very good quality of life and were very positive in both outlook and the work they diligently committed to through the GIA scheme. The evaluation also indicates that many rediscover old skills, learn new things, and become more aware of their own needs and the needs of the young people they come in contact with in the wider community. The volunteers also gain in confidence, find companionship and enjoyment through their work.

An interesting initiative in **Sweden** aims to sensitize employers. The Swedish Voluntary Agency has promoted company volunteering. It aims to convince employers in Sweden to let their employees volunteer two hours per month every year on paid time. The Agency is currently working with insurance companies, banks, etc. to help them find volunteering for their employees.

Finally, in Poland, according to Law on Public Benefit Activity and Volunteerism, with respect to health care, a volunteer carrying out a service in the framework of this law is automatically covered by the general national healthcare insurance. In case of accident while performing a volunteer activity, the individual is entitled to compensation¹⁴⁷.

3.4 Conclusions

Several programmes favour active ageing, notably:

¹⁴⁶ <http://www.talkoorengas.fi/sairvap.htm>

¹⁴⁷ Source: AVSO & CEV Project: Legal Status of Volunteers: Country Report: Poland

- Social centres for seniors where they can participate in activities with others seniors
- Promoting structures enabling elderly to be an active independent and assertive part of society
- Programmes of health promotion and health prevention
- Improving the communication capabilities of the elderly through the instalment of Internet cafés for seniors and a communication and discussion platform with Internet training offers
- Strategic management, activities and activity evaluation in welfare and health issues
- Incorporating prospective assessment in municipal decision-making
- Plan for health at work (improving the prevention of occupational hazards)

Volunteering by senior citizens has been strengthened through, notably:

- Programmes enabling old volunteers to continue their job through volunteering
- Programmes recognising and valorising the skills and abilities of senior citizens
- Academy for Seniors and Society (become a voluntary consultant for non-profit organisations)
- Programme aiming to develop intergenerational activities at neighbourhood level
- Enable older people to engage in helping younger members of the community through the use of mentoring and other one-to-one activities.
- Initiatives to sensitize employers to promote company volunteering
- A volunteer carrying out a service is automatically covered by the general national healthcare insurance.

An increasing number of Member States acknowledges that volunteering play an important role for an active and healthy ageing. Consequently, recent national health programmes or programmes specific for elderly people promote volunteering among elderly people.

Often, these programmes favour activity and participation through the valorisation of seniors' expertise. In summary, functional voluntary projects included some common features. First, they gave possibilities for older citizens to use their talents, skills and knowledge in the meaningful way in various activities of the society from support to other people to moving their knowledge and experience to younger generations. 'Senior trainers' renew the image of the older age and age in general both among younger persons but also among older persons.

In order to make it possible, certain initiatives provide training to elderly people. Training senior citizens as consultants recognises and valorises the skills and abilities of elderly people. The training actively contributes to the ability of older citizens to live their life according to their own wishes as long as possible. The use of the experience of older people is aimed at older people who are not (only) involved in traditional voluntary work, but who want to contribute their expertise and skills flexibly, shape their involvement for themselves and act as multipliers.

Local centres often propose activities and favour communication among the elderly at a local level facilitating personal development, social participation, healthy lifestyles and positive attitudes towards ageing.

IV.4. Labour market participation and informal caring

4.1 Introduction

In the following, a selection of policies having a positive impact on reconciliation of long term care and work shall be highlighted.

4.2 Examples of good practice

➤ Awareness of employers

A good example for raising awareness that there is an actual problem of reconciling work and care can be seen in the work of the **British** government's Department for Education and Employment which launched the "Employers for Work-Life Balance Initiative" which aims at encouraging organisations to make a commitment to support carers in the workforce. Similar is the "Work-Life Balance Campaign" which aims at raising employers' awareness of the business benefits of introducing policies which help employees obtain a better balance between work and family life, also embracing family care.

Going even further, the British Government set up the "Work-Life Balance Challenge Fund (WLB-CF)" which provides financial aid to employers to help them develop work-life balance policies and practices. "Evidence from a 20-month independent evaluation of the first three rounds of the WLB-CF indicates that the vast majority of employers have positively benefited from participation in the Fund. The findings indicate that the WLB-CF has enabled employers to introduce significant changes in their employment practices so as to create greater awareness of, and develop policies to support, work-life balance."¹⁴⁸

➤ Facilities for respite care

In **Sweden**, a three-year Action Plan from 1999-2001 (Anhörig 300) provided funding for local governments to develop an infrastructure of services targeting family carers. Municipalities were stimulated to expand non-financial support for informal carers e.g. by setting up caregiver resource centres that offer training, counselling, support groups, respite care and other programmes. As a result, the number of support programmes available has steadily increased.¹⁴⁹

Respite care was already available, but the variety increased. Practices such as day care and replacement of informal care givers at home is now available in more municipalities. Practices of counselling, training and contact points also have become significantly more popular than before.

"The evaluation by the Swedish National Board of Health and Welfare concludes that municipalities have continued the efforts to develop the range of non-financial support for informal care givers, but it is difficult to know whether these support services reach the people who need them most and there is a continued need for developing their quality. Developing the appropriate form of help is a challenge, and surprisingly often informal care givers said "no thanks" to offers of support."

¹⁴⁸ Nelson et al. 2004 (ADRIAN NELSON, KATHRYN NEMEC, PERNILLE SOLVIK and CHRIS RAMSDEN (2004): The evaluation of the Work-Life Balance Challenge Fund; EMPLOYMENT RELATIONS RESEARCH SERIES NO.32; DTI; UK).

¹⁴⁹ Johansson, Lennarth, (2004).

➤ Flexible work arrangements

In **Austria**, according to the Labour Contract Law Amendment of 1997, employees who have temporary care obligations can claim part-time work. After finishing the care work a return to the former working time should be possible.¹⁵⁰

In **Germany**, in 2001 the general right to work part time was introduced for employees working in companies with 15 and more employees. This allows a bigger choice in what to do with ones time. It is planned to introduce on 1st of July 2008 a right to six months care leave with job return guarantee.

In the **Netherlands**, the 1998 Act to Finance Career Interruptions permits employees to take leave for at least half of their regular working hours for between 2 and 6 months (can be extended by local labour agreements to 18 months). The person taking leave receives a payment of €11 an hour, up to a maximum of €436 for leave of 38 hours or more a week. Additional periods of leave can be taken so long as there is at least a year between them.

“In the **United Kingdom** - from April 2007 - the Work and Families Act 2006 gave certain carers the right to request flexible working such as changing hours or working from home. This act extended the right – which came into force in April 2003 – of parents of children under six, or 18 if the child is disabled, to ask for flexible working. Employees who have worked for their employer for at least 26 weeks can apply to make a permanent change to their terms and conditions. Only one request is allowed in a year. Employers can refuse a request, but must give good reasons. Employees can appeal. Parents of disabled children have had the right to request flexible working for the past three years. Research shows that four in five requests are granted. The right to request flexible working could make the difference between a carer quitting or remaining at work. Currently, 2.65 million carers could take advantage of this new right, but millions more will benefit in the years ahead.

The act defines a carer as “someone who cares for, or expects to care for, a husband, wife or partner, a relative such as a child, uncle, sister, parent-in-law, son-in-law or grandparent, or someone who falls into neither category but lives at the same address as the carer”. People who care, say, for an elderly neighbour, fall outside the remit of the act. Evidence shows that most employers are open to requests from those not eligible under the new law.

In addition, under the Employment Relations Act 1999, employees gained the right to “reasonable time off” to deal with any unexpected situations that arise in relation to their caring or parental roles. At the discretion of the employer, time off can be paid.”¹⁵¹

➤ The choice of carer

In the **Netherlands**, persons assessed and eligible for non-institutional care, can ask for care in cash (“personal budget for care”, PGB) or care offered in kind. In 2001, there were five different schemes (allowance for help and care at home, intellectual deficiency, mental health, intensive care at home and physical disability). The reform of 1 April 2003 replaced all schemes by one, the personalised budget new style. In 2006, there were 90.000 beneficiaries¹⁵². About 70% of new beneficiaries in 2005 had a “somatic” deficiency.

A person who is entitled to care under the Exceptional Medical Expenses Act can opt not to take care in kind, but to receive a personal care budget. In principle, anyone who requires care under the Act for more than three months can qualify for such a budget. The budget is a sum of money awarded to the client to enable him/her to purchase care independently. However, the budgets are available only for certain functional forms of care, such as nursing, general care and guidance; they are not available for treatment or institutional accommodation. The minimum disability level required to be eligible is the

¹⁵⁰ Barkholdt C. and Lasch V., (2004).

¹⁵¹ <http://www.carersuk.org/Employersforcarers/Thebusinesscase/Carersandthelaw>

¹⁵² Rapport Uitvoeringsverslag PGB nieuwe stijl; juli 2005 – juli 2006; Publicatienummer 244; CVZ, 2006, http://www.cvz.nl/resources/rpt0611%20uitvoering-PGB-juli2005-juli2006_tcm28-22372.pdf

existence of care functions restrictions. Eligible people cover all ages (beneficiaries of the Exceptional Medical Expenses Act).

The beneficiary can choose to pay his own caregiver. He may pay their own relatives for the care or they can buy customised professional services.

“A study of the outcome of the *Personal Budget* scheme in the Netherlands, which found that while care quality is roughly the same as when persons needing care are referred administratively to a designated agency, persons receiving care through a personal budget feel less dependent because they have more control over when care is provided and notably by whom.”¹⁵³

In **Germany**, the Long term care insurance benefits can be received in the form of a cash payment (at a lower value); or in the form of professional home care services (worth nearly twice as much); or as a combination of the two. The level of the cash benefit option depends on the level of ‘care dependency’.

The cash benefit option is only payable if the care insurance recipient is able to secure adequate home care from relatives, friends or neighbours. The cash benefit is awarded directly to the person needing care, who may then pass it on to a family carer.

Despite its significantly lower value, the cash option has proved much more popular than ‘in kind’ services.

Once an older person’s entitlement to care insurance has been established, a number of other benefits can be received which are of potential benefit to family carers. These are¹⁵⁴:

- Respite, holiday or stand-in care: Informal carers providing home care can take up to 4 weeks holiday a year, during which the Long term care insurance will pay for substitute professional home care services. The same entitlement is available if the usual carer is ill.
- Insurance cover: Care insurance pays the retirement pension and accident insurance contributions of informal carers who are employed for less than 30 hours a week and provide unpaid home care for at least 14 hours a week. Informal carers are also automatically covered by the statutory accident insurance scheme while they are providing unpaid home care.
- Direct support for carers: Care insurance beneficiaries who have chosen the cash option have a home visit from a nurse employed by the care insurance fund every 3-6 months, depending on the level of care dependency. This is partly to monitor the quality of care being received and partly to provide advice and support for carers. The Long term care insurance funds are also required to offer free nursing care courses for informal carers; Carers are also entitled to retraining opportunities if they want to return to paid employment after a period of care-giving.

➤ Insurance cover

In **Germany**, care insurance pays the retirement pension and accident insurance contributions of informal carers who are employed for less than 30 hours a week and provide unpaid home care for at least 14 hours a week. Informal carers are also automatically covered by the statutory accident insurance scheme while they are providing unpaid home care.

Similar measures and pension accruals apply in Finland (see below).

In **Austria**, since 2006, in addition to social insurance statutory protection for carers who are relatives, a preferential personal insurance for periods of care for close relatives was created; according to this, people who are caring for a close male or female relative with a right to a long term care benefit,

¹⁵³ Lundsgaard (2005) (Jens Lundsgaard (2005): Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care: How Can it Help Improve Care Outcomes, Employment and Fiscal Sustainability? OECD HEALTH WORKING PAPERS NO. 20)

¹⁵⁴ Caroline Glendinning: Support for carers of older people – some intranational and national comparisons: A review of the literature prepared for the Audit Commission, Audit Commission, UK, 2004

placing considerable demands on their capacity for work in the home environment, may be self-insured in the pension insurance scheme under favourable terms. Only one person may be self-insured for each case requiring care. Care in a home environment is not interrupted if the person requiring care has a temporary stay as an in-patient. In the cases of this newly created preferential self-insurance in the pension insurance scheme for periods of care by close relatives, the Federal Government, as is the case for the existing opportunity of preferential further insurance in a pension insurance scheme, assumes the fictitious employer contribution. Through this new opportunity for self-insurance, statutory social insurance protection is also created for those relatives who are carers and who have either not yet been amongst the insured or for whom taking up the benefits which existed to date for carer relatives was not an issue because they did not fulfil the statutory requirements.

➤ Support for informal care

In **Finland**, the municipality can give support for informal care for relatives who look after an older person, a person with disabilities or a long-term ill person. The Act on Support for Informal Care came into effect at the beginning of 2006. Support for informal care is a statutory social service. The municipality is responsible for organising the support within the limits of its resources. Support for informal care encompasses necessary services for the client, a compensation for the informal carer as well as leave and support services for the carer. The municipality and the person providing care draw up a care agreement (which is a commission agreement between the municipality and the care giver, not an employment contract) that includes a plan on care and services. In 2006 the minimum caregivers allowance is EUR 300 a month. There is no upper limit on the allowance, which is taxable. The caregiver who has made an agreement with the municipality is entitled to employment pension accrual with certain limitations. The municipality also covers the caregiver's accident insurance. People receiving support for informal care are entitled to two free days a month during a period when the nature of the care they have provided has been very demanding. During this statutory free time, the municipality is responsible for providing care to the elderly recipient. The municipalities may organize supplementary holidays for the caregiver and free time for recreational activities of less than 24 hours¹⁵⁵.

4.3 Conclusions

Innovative practices focus notably on:

- a consensual approach (sensitisation of employers),
- extension of local support services to carers and the dependent person,
- part-time work and flexible work hours,
- allowances and personal budgets which formalise informal caring,
- insurance and pension credits to avoid long-term negative impacts on the carer, and
- Support to carers.

Generally, the different measures aim to improve the quality of services provided to dependent people and improve the work life balance of carers.

¹⁵⁵ Ministry of Social Affairs and Health: www.stm.fi

PART V

Policy implications

V.1. Health and labour market participation

Self assessments on health and chronic illness reveal big differences across Member States. Differences across countries may stem from institutional and country specific characteristics as well as from personal situations and characteristics. Different researchers have stressed the role of education and working conditions. Econometric analysis indicates that lower education level, occupational level (current or previous) or relative income increases the probability to report a longstanding health problem or condition.

Several empirical studies have shown that health is a determining variable for labour force participation and therefore for the labour supply of older workers. Even if there is no consensus about the magnitude of health effects relatively to other variables, the health factor is acknowledged to play an important role.

Poor health and notably a deteriorating health (physical or mental) lead to early retirement, absenteeism from work, disability and low job satisfaction. This impact may be immediate but certain effects may be distributed through the life cycle.

Constraints on the labour market may play an adverse impact on health. However, working conditions do not cover only material constraints. Involuntary retirement also might create stress and aggravate existing health problems. A strong attachment to work (full-time jobs, long work histories) and a lack of control over the transition to inactivity are predictors of difficult adjustment and health problems.

Most individuals in bad health will stop working at an early stage while individuals in good health will retire later. Econometric analysis sustains the traditional results that a higher education and occupational skill increase the probability to participate on the labour market.

Also, people who exit the labour force report a higher prevalence of chronic (longstanding) illness or condition compared to those who stay in the labour force. People with mental health problems and “other progressive illness” constitute the most vulnerable groups. The exit rate of this group is relatively high and the (re) entry rate is low. Further analysis of those who exit the labour force reveals that they have a long history of unemployment.

There is an important gender difference relating to health and labour force participation. Women with health problems follow the general pattern of women’s labour participation. On the contrary, men with health problems seem to be sensitive to specific factors. General policies will affect them differently.

The gender gap has received little attention in national policies reviewed here despite the fact that women’s inactivity rate (at advanced ages) remains relatively very high.

➤ Health management

Several European countries developed national programmes for active ageing and in these programs health management is a key point. Certain countries encourage age oriented policies at the company level.

Different approaches have been adopted based on Job requirements (Denmark and Sweden), disability and rehabilitation (Germany), a global health approach (Finland), working conditions (France, UK), financial schemes (Disability pensions in the Netherlands) and consensual approaches (Nordic countries).

Nordic countries and in particular Denmark, Finland and Sweden have invested in health management of older workers through many programmes and policies. These policies and programmes favour the

transfer of older workers to less physically demanding tasks, part-time, job adaptation, etc. In this framework, Nordic countries aim to reach companies and favour an active participation of employers. They promote a consensual approach between all involved parties.

Supporting employers to introduce senior policies at the firm level seems a promising channel. However, these solutions are specific to each company. Consequently, the real solutions can only be designed inside companies. Technical and financial assistance to private enterprises could favour age-oriented personnel policies e.g. the use of flexible part-time employment, assigning tasks with less physical burden to older employees, implementing special training measures for older employees as well as using job-rotation measures.

The fact that such initiatives are profitable for companies is also one reason for their success. Another important factor for success is a consensus between company and trade unions (Denmark and Sweden). Furthermore, measures which are incorporated into the company's normal routine have a higher chance for success. Results to date are very encouraging and demonstrate that poor or moderate work ability can be improved, while good work ability can be maintained. In certain cases, these policies lower absenteeism.

Prevention of professional risks often involves programmes through which all employees and especially older ones can take regular health checks. They could then receive medical advice, or be referred to a general practitioner in order to tackle common health problems. Also, the company expert might assess possibilities for flexible working options such as part-time, taking work with lower level of flexibility or full or part-time sabbaticals. By attracting and retaining talent to the organisation staff turnover can be reduced and sickness absence decrease.

The governments could provide financial and technical assistance to companies which adopt such policies, notably to reach people with light health problems and disabilities in small and big companies (e.g. Germany). The importance of the introduction of age-oriented personnel policies in small and medium-size enterprises is recognised in several countries. These companies have only little possibilities to handle this on their own. Projects that were carried out showed, that it is necessary for enterprises of this size to have easy access to information and help.

Current policies aiming at people aged 50 or more might have a limited impact. Those who exit the labour force have a long history of unemployment. Consequently relevant policies ought to target people at younger age groups too. They ought to prevent marginalisation instead of tackling it once it appears at an advanced age.

➤ Part-time work

Available surveys indicate that part-time work is important for women and people with chronic (longstanding) illness or condition. Part-time work is a preferred way to (re) enter the labour force of those who were previously inactive. This is true both for people with and without chronic illness or condition. Part-time work usually involves a reduction in income.

Part-time work due to illness or disability and voluntary part-time work increases with age. For men, mental health problems and other progressive illness are the more restrictive types. For women, speech, other progressive illness and skin appear to be the most disadvantaging.

The review of the literature and the statistical analysis revealed that part time work was a desired option for older people with health problems. Also, helping workers in bad health by adjusting their working time to their working capacity may avoid some early retirement. However, the expansion of part-time work has to overcome a certain number of barriers such as the income loss of the worker, discrimination on the workplace and opposition from employers.

In most European country, ageing policies are elaborated in order to increase the labor force participation of older workers. Phased retirement and part-time work for older workers are important axes of ageing policies in European countries. All European countries have adopted measures concerning part-time for older workers but only a few insist on older workers with health problems.

A negotiated procedure seems desirable and collective agreements aim to organise part-time work of older workers in sectors with physically demanding tasks. In Denmark, collective agreements provide for special clauses concerning part-time employment of older workers. Agreements between workers and employers are also promoted in Belgium, while in France and Germany, certain industrial sectors provide for part-time work for older workers.

Part-time workers might face discrimination (e.g. in promotion opportunities) or face a sharp reduction of their income. This might be an important barrier to part-time employment. National policies aiming to guarantee equal rights with full time workers and compensation for income losses might help maintain people with chronic health problems on the labor market. The early Dutch initiative to guarantee equal rights for part-time workers is interesting.

Summarising, we can say that Member States favour flexibility of working time for older workers with health problems notably through phased retirement and part-time work, collective agreements concerning part-time employment of older workers, suppression of impediments to part time work, protecting social rights of part-time workers and possibility to draw at the same time a pension and income from part time work.

An obstacle to part-time work might be low resources. Austria, The Netherlands and Finland compensate income losses due to reduced work hours. Several countries (notably Poland and Sweden) make it possible to draw at the same time a pension and income from work.

➤ Prospects

Results to date are very encouraging and demonstrate that poor or moderate work ability can be improved, while good work ability can be maintained. In certain cases, these policies lowered absenteeism.

Generally, the Member States have tried to rise the effective retirement age through different channels, notably: abolition of early retirement schemes, rising the retirement age, penalising early retirement, increasing controls, etc. The measures described above indicate that there are alternative policies based on free choice and social consensus.

Policies aiming to increase the choice of workers and employers on a consensual base might be less costly both for companies and public budgets.

Future policies might focus on:

- 1) Developing diseases prevention and Health Education; Policy emphasis is necessary to prevent as much as possible the onset of chronic diseases and disabilities among older workers.
- 2) The improvement of the working conditions as it plays an important role on health and thus on the labour supply.
- 3) The elaboration of individualized and flexible work devices for people with chronic illness or disability.
- 4) The responsabilisation of the companies face to the abusive use of the pension's schemes or private pre-retirement measures.

- 5) Provision of technical assistance to social partners, notably skills training for managers and career planning.
- 6) The sensitisation of employers for consensual solutions inside the company.
- 7) Legal devices of fight against discrimination (in particular on age and health).
- 8) Increasing the female labour participation and employment rate through investing in the system of care and long-term care.

A senior's policy might face opposition from social partners. The reallocation of tasks (assigning older workers with health problems to less physically demanding tasks and ergonomic adaptations) and shorter working hours might imply undesirable changes for other workers. Consequently, a consensual approach and the involvement of social partners are desirable.

The existence of flexible work time arrangements seems to play an important role. Part-time work appears to be a determinant factor. This requires law adaptations in order to guarantee equal rights for part-time workers and eliminate discriminations.

It is important to work towards two directions. First, retaining at work workers with health problems through an early intervention, and secondly, re-integrating at work workers after a lengthy process of rehabilitation, if possible in the same company.

➤ The challenge of disadvantaged groups

The gap in life expectancy between lower and higher level occupations poses a serious problem to the policy maker. People reach legal retirement age with a different life expectancy and consequently different attitudes concerning work and leisure. Activation policies concerning labour participation of older workers and social participation of elderly people ought to take into account this life expectancy differential. Uniform policies risk reaching only educated people who had higher level occupations and benefit from a good health and higher life expectancy at retirement.

Heavy and dangerous occupations may require a lower legal retirement age. One solution might be to link retirement age with life expectancy. Promising measures include incentives for employers to accommodate health impaired workers or intensified use of medical rehabilitation programs.

Proposed policies to increase the effective retirement age ought to take into account the specific needs and potentialities of certain disadvantaged groups. A certain number of older workers can not work longer. Adding constraints on the earliest eligibility age for retirement could disadvantage further these groups. Also, additional restrictions concerning early retirement may strain social programs like invalidity benefits that would likely end up serving more people. Finally, extending the work life of these persons might increase long term care needs and transfer the cost to their family (e.g. informal care). Consequently, withholding benefits until a later age might hurt those with shorter life expectancies, and favor those with longer lives.

Old-age policies and social security reforms aiming to increase the labour force participation of older workers may have an adverse effect on people with health problems (e.g. older blue-collar workers). This has obvious consequences, for instance, for health care consumption at advanced ages. The policy criterion here is not the sector of activity but the occupation. As noted in several occasions, the level of education (skills) and job requirements (heavy tasks) are the determining factors. Consequently, policies organised around industrial sectors or branches might be discriminating to certain groups of workers with high morbidity and/or invalidities (e.g. unskilled manual workers).

V.2. Financial (dis) incentives

At the outset of this concluding section, three remarks are in order. Even though they are obvious they are also very important. First, there are wide differences across countries both in current practices and in reforms. Sweden and Finland are already benefiting from past reform whereas Italy and Germany are still expecting recent reforms to significantly boost activity levels in old age. Second, raising employment rate should result from many interconnected, yet somewhat modest initiatives and policy measures. Strengthening work incentive in social protection systems is important. But at the same time, it is crucial to conduct active labour market policies, to ensure better health in working life and provide lifelong learning. Third, these interconnected initiatives cannot be taken at the same time. Some are more difficult to implement and involve long lags. For example, increasing the tax-benefit incentives to prolonged activity can be decided rapidly and its effects are likely to be rapid. By contrast, improving lifetime working conditions with the objective of working longer and in better health will take time.

Keeping those caveats in mind, let us turn to the central question, that is what is the role of social protection and tax transfer schemes towards implementing active and healthy ageing policies.

The review of the literature reveals that in many European countries tax-transfer policy and social protection have the opposite effect. By discouraging prolonged activity well before the statutory age of retirement, by prohibiting paid activity after retirement social protection contributes to passivity and not to activity in old age.

As a consequence, a large number of elderly workers, most of them healthy, are pushed out of the labour market. This is costly for society making it difficult to decently finance pensions and health care. This can also be damaging for some workers for whom inactivity is unhealthy.

Consequently, the first recommendation one has in mind is for Southern and Eastern European countries to follow the path of Nordic countries and increase the activity rate of the population aged 55-65 and even 55-70.

Reforms that lead to higher activity rates among elderly workers have to be accompanied by a strengthening of disability and health insurance for those workers who cannot work longer for either frail health or work hardship.

At the same line, progressive and not sudden retirement ought to be recommended. This raises some technical problems, but this is also known to make the landing into retirement physically and psychologically less painful.

Concretely, to raise the rate of activity of elderly workers, including in this concept not only the 55-65, but even the 55-70, one has to make the whole social protection system less distortive. This implies abandoning explicit early retirement programs and implicit early retirement programs such as the use and abuse of disability insurance.

This implies also reforming earnings tests in countries where they still exist. By the same token, this implies allowing people to work even beyond the statutory age of retirement. Those reforms would make the whole social protection system actuarially neutral towards the retirement decision.

It is worth noting that the current evolution observed in about every European country, that is an evolution toward defined contribution systems, public or private, is a driving force towards actuarial neutrality.

Such an evolution must be welcomed with caution for two reasons. First, it is important to keep everywhere a safety net program for those workers who have been unable to accumulate enough pension rights. In other words, minimum pensions are needed. Second, it is important to maintain an effective disability insurance for those who are unable to prolong their activity even before the statutory age of retirement. To avoid abuses, credible disability tests are in order. In that respect, the recent example of the Netherlands is speaking for itself.

The Netherlands for decades experienced huge abuse of disability insurance; those abuses were in fact supported by everyone, the government, the unions and the employers. This situation has changed by restricting the accessibility of disability insurance to truly disabled workers. Note that in a well functioning country with high activity rates among elderly workers, one expects to have many workers drawing benefits from disability insurance.

In some countries, there is a political resistance towards increased controls on the use of both disability and unemployment insurance. It needs a lot of explaining to show that controls are the price to pay for more generous compensations.

The benefits from prolonged activity are not just financial. It is clear that by raising the effective age of retirement, one decreases the rate of dependency and increase the sustainability of social protection programs aimed at the elderly.

The benefits of working longer are also psychological and physiological. The evidence shows that even though health problems can lead to early retirement, early retirement can also trigger health problems. We live a world of heterogeneity and it is important to have social protection systems that are responsive to two contrasting situations: frail health leading to retirement and postponed retirement keeping people healthy.

Actuarial neutrality does not solve everything particularly when it can only be partial. To avoid the pervasive problem of financing it is important to link the key parameters of pension system, particularly the ages at which benefits can be drawn, to longevity. Some countries (e.g. Sweden) are now having such a link that guarantees the financial sustainability of public pensions.

Actuarial neutrality should extend beyond formal retirement. That is it should be possible to work past the pensionable age. Some European countries reduce pension benefits at high effective withdrawal rates for those who work after retirement and whose earnings exceed a certain threshold whereas those earnings tests can be explained when pension are redistributive they are not when pensions are contributory. Allowing people to work generally part time after retirement should be allowed. The benefits of abolishing earnings tests are obvious; they are psychological and financial. The costs are inexistent. We now know that earnings tests don't have any effect on unemployment.

Activity past the pensionable age is not restricted to market work. It can also include non market work within the family or in the non profit sector. It is desirable to encourage activity within the family either towards grand children or towards dependent parents. In some countries, particularly where public services are lacking, people aged 55-70 are already involved in those kinds of activity. It would be desirable to adopt a two-direction policy: (i) to extend this type of activity and (ii) to make it optional and not mandatory. There are too many cases where family members, women in particular, are trapped in what can be called forced altruism. In those cases, support from the state would be

welcome. For example, availability of institutionalised care for either grand children or dependent parents a couple of days per week could relieve some and encourage some others.

What makes difficult the intervention of public authorities in family solidarity and volunteering is the risk of crowding out. It is indeed tempting for people who have been freely providing assistance to others in the absence of subsidies or social amenities to use these when they are introduced. This explains why so often public intervention consists of in kind transfers or in services of relatively lower quality. These problems would disappear in case of perfect information. A partial solution is to make the provision of subsidies and social services at the local level. At this level, one has better information regarding the needs and the means of citizens.

One of the challenges of social policy aimed at the elderly population is to optimally use the contributions of the market and the family to achieve the objective of balanced activity and appropriate care. With increasing longevity, we indeed have a population in need to be maintained active and also a population in need of long-term care. The real challenge is to postpone as much as possible the dividing age between activity (market and non market) and dependency.

Finally, it is interesting to note that activities after retirement, either market or non market one, have a depressive effect on the age of retirement particularly when they are attractive. In other words the need to take care of a dependent parent or the need to get involved in a charitable organisation have the same effect on the decision to retire as early retirement programs. This shows the complexity of labour force participation in old age. It also shows that public authorities face an arbitrage between market labour and a variety of non market activities.

V.3. Active ageing

3.1 Active ageing

Ageing and quality of life are not necessarily in contradiction, but well-being at greater ages depends heavily on the capacity to keep physical and mental health at higher level. For this purpose, active ageing was identified as the main positive driven factor. We distinguish here the key dimensions that appear to be highly correlated with active ageing and, for this reason, representing the most important fields for policy implementation.

Education

Scientific research studies show that educational attainment is by far the main driver in favour of active and healthy ageing. But educational gaps among individuals measured across and within countries, are great and persistent. That means that an improvement in education, for all categories of the population and at all ages, is a first best policy orientation. Other than the long term impact of valuable educational reforms, in the meantime measures can be taken to increase the offer and the demand of educational training programs addressed to adults and aged people.

Recommendations in this direction include:

- Increasing the participation in education and training programs among adults and elderly people (Denmark and Sweden)
- The development of E-learning possibilities would be helpful to reduce the age-related technological (numerical) gap.

Lifestyle patterns

Neurophysiologists agree on the importance of lifestyle patterns to keep cognitive functions at a high level, even at greater ages. Important gaps are observed across and within countries, across individuals and socioeconomic categories. Maintaining aged people at work, in professional or non-professional activities, at later ages is a natural way to keep them active and healthy. But also all other occupational activities implying complex information treatment tasks favour cognitive reserve maintenance.

We may note the following suggestions:

- Information campaigns on healthy ageing (France, Sweden, and United Kingdom).
- But disadvantaged groups, living in poor economic conditions, must be the priority.

Professional activities

Good and healthy working conditions are a minimum requirement to encourage aged workers to delay retirement. Some countries, particularly Denmark, Finland and Sweden, succeeded by introducing *age management* reforms that simultaneously addressed working conditions issues, suppressed financial incentives in favour of early retirement and, overall, fight against age discrimination beliefs.

Recommendations include notably:

- The organisation of systematic of career-planning discussions for workers aged 55 (Sweden).
- Cross-sectional Employment Programme (Finland).
- Flexjobs (Denmark).
- Work and Care Act (The Netherlands).

Other activities

Concerning other activities, we may note that the regular exercise of physical activities as well as the participation to social and cultural activities is synonyms of active ageing. These activities cannot be imposed and to a certain degree will depend for each individual on her/his degree of social integration. The family and the social network are very good providers, as well as the market represented by profit and non-profit institutions and associations.

Policies devoted to the promotion, and in some cases, the direct organisation of these kinds of activities by public institutions are necessary (The Netherlands, Poland, and United Kingdom). In this case, the targeted population will correspond to those categories suffering of a certain degree of social isolation.

We also have to mention that Share provides data infrastructure for fact-based economic and social science analyses of the on-going changes in Europe due to population ageing. The original 8-country survey has already being expanded to cover two new Member States. Ideally SHARE will expand to all 25 Members States of the EU. It's important for Europe to have good evaluation tools of ageing population. This is why SHARE has become an infrastructure financed by the EU. A better knowledge of the ageing population in Europe will lead to improved policies.

3.2 Volunteer work

In terms of active ageing, voluntary work presents many of the advantages of professional work without its main disadvantages. But they are mainly culturally driven, as illustrated by the North-South EU gradient in voluntary work participation rates. However, policy makers may focus on a certain number of factors which are important for volunteering.

In terms of active ageing, voluntary work presents many of the advantages of professional work without its main disadvantages. Furthermore, participation in voluntary work may hinder social marginalization and may enhance well-being of the older volunteers. Society may get advantages in many ways: older persons may stay active for longer and their precious skills are not lost. However, volunteer work can never be a substitute to professional work, for instance in the care of the elderly. The main challenges in activating persons to do voluntary work are to inform and motivate people, to find a suitable way of volunteering for each person who is willing to participate, and to train people. But they are mainly culturally driven, as illustrated by the North-South EU gradient in voluntary work participation rates.

Recommendations in this direction include, notably:

- Senior training initiatives (e.g. Germany and the Netherlands);
- Inter-generational support programs (e.g. Austria, Slovenia and UK);
- Governments may direct financial support to advertising and to establish volunteer centres (e.g. Austria) where persons are given information on volunteering and training and they can find a suitable ways to participate. In these centres volunteers can meet other people and get support;

At a European level, general guidelines could be organized that could be applied in various countries. This model may include recommendations on governments' role, and volunteer activities included in local centres. Each centre may find its own local organisations that are interested in directing projects or perform their own volunteer activities via centres. The guidelines could pay attention in competition legislation and the particular role of voluntary organisations.

Official (governmental or policy) role in volunteering should be kept marginal. However, if volunteering is hoped to have a functional active role in society, it needs some promotion. Governments can act by giving possibilities to volunteering by financing advertising and the establishment of centres.

In addition, in order to enhance the volume of volunteering, the promotion of volunteering should be begun before retirement age. It is unlikely that people would start volunteering once they are not gainfully employed. If people are involved in some voluntary work when they are at working age they are more likely to continue that when they retire. One way could be to give possibilities to volunteering during last years in work force; older workers could be given a permission to use few days a year in volunteer activities (e.g. France).

Programmes organised at a local level are better suited to reach disadvantaged elderly people. In fact, focussing only on voluntary work and the valorisation of skills may increase further the social gap concerning health. Proposed programmes ought to pay a special attention on ways to reach the most disadvantaged people as generally they are less healthy and less likely to be reached by general information campaigns. One important factor is to avoid costly activities and enable the reimbursement of costs generated by volunteering.

Concerning people with activity limitations, we have to note that volunteering and conditions required for disability pensions might enter into conflict. In this respect, the exercise of a benevolent activity ought not to constitute a cause for revising incapacity rates. This could be done at least for activities which promote social participation and favour the establishment of social networks. In fact, social isolation might be a deteriorating factor for several impairments and activity limitations.

Finally, there is an important dimension which is not often taken into account. This is the conditions under which volunteering takes place. A special attention ought to be given to this aspect in order to avoid accidents, falls and other risks associated with age.

V.4. Labour market participation and informal caring

Enabling informal carers to work and care at the same time is one of the big future challenges in long term care. At the one hand societies are dependent on informal carers and on the other hand they are in need of qualified workers. However, work and care compete about scarce time budgets thus policies have to facilitate their combination.

An important dimension is the number of hours spent. Difficulty in combining paid work and informal care seems to particularly affect those undertaking substantial hours of caring per week. After controlling for different factors, caring has a significant negative effect on hours of work. The amount of time spent caring differs widely between Member States. Whereas the number of persons providing light help outside the household is highest in Nordic countries it is lowest when it comes to the category of heavy caring. Women provide relatively more demanding help than men.

Available data indicates that the vast majority of carers are women, notably in the age group of 55-64, where labour participation is low. Caring for adult decreases labour market participation (notably for women). This is particularly clear in ages where child care might be an additional time constraint. About 25% of persons looking after children or adults declare that this prevents them from undertaking the amount or kind of paid work which they otherwise would do.

The different studies agree that all European countries are expected to remain dependent on family care. However, the awareness and supporting policies to reconcile work and long-term care are not that widely spread as they should be. It can be observed that countries that have a general positive approach to enable the combination of work and family life are doing much better to support also the combination of work and long-term care.

As described in part one, member states have different approaches to social care in general. Reconciliation of work and family care is notably difficult in countries which follow a family care model which does not address the issue of reconciliation. The central European subsidiary model is more aware of conflicts and developments to facilitate reconciliation in the respective countries can be observed. It is not surprising that care and work can be combined best in countries which see care as the responsibility of the state.

With the main trend, the move from institutional care to home care reconciliation of work and care becomes also an issue in countries that see care as the responsibility of the state. The availability of home care services is differing from country to country. Cost reduction for the state does frankly result in higher costs for family carers as home care mostly has to be supported by family care.

In this context intensity of family carers has to be considered: Care over 10 hours a week significantly influences labour market participation of carers. Hence, any policies which are requiring stronger involvement of home carers have to consider possible negative labour market effects.

Flexible working time arrangements are necessary to combine work and care. This aims at the general possibility of part time work as well as short term leaves in emergency.

Special attention has to be given to women as care is mostly provided by women. Thus, women are mostly affected by reconciliation difficulties. For them, at the one hand policies aiming at part-time work simplify reconciliation but on the other hand negatively influence wages and career prospects.

Taking into account that long term care, as well as care in general is performed mainly by women, policies to promote the reconciliation of work and long term care should consider the specific needs of women. However, policies should not aim at women only, as societal expectation of women as

caregivers would be cemented. Policies should set incentives for men to take on care obligations as well.

Main barrier to policy implementation is a lack of awareness of the reconciliation difficulties and also a policy approach not considering the needs of the carers. Most member states focus their policies on the care receiver not the caregiver. To strengthen the position of the carer especially concerning the reconciliation of work and care a clear policy focusing on the carer should be implemented. In addition, these policies should also focus on carers which spend a lesser amount of time caring. When care demands 35h/week and more there is usually no question of reconciliation any more but of opting for care or work.

Simple financial incentives to provide family care can be counterproductive to labour market participation. In addition to remuneration special flexible working time arrangements are necessary not only to leave a choice to care or not but also a choice to care to what extent.

Some countries have a general backlog in the provision of care facilities not only for long-term but for all forms of care. The provision of flexible support services and facilities is the key to enable the reconciliation of work and long-term care.

Main obstacle in some countries to combine work and care is the lack of facilities for respite care or similar services. Different degrees of home care Services are available in most EU- countries. Good additional demand oriented services e.g. respite care and day care centres are available in Belgium, Denmark, Sweden and Finland. Also the improvement of child care facilities is important as many carers are sandwiched between caring for children and elderly at the same time. Good care facilities for one side will benefit the other.

Most member states show an awareness of the difficulties of combining work and long term care and develop policies to facilitate reconciliation. It is useful to have a closer look at the single countries' efforts to tackle the problem.

The British government's Department for Education and Employment which launched campaigns to raise especially employers' awareness that there is a difficulty to combine work and family life, including long-term care. This can be seen as a consensual approach for further policy developments and practical arrangements in companies.

Countries with general high labour market participation also have high labour market participation of carers. Especially high levels of women on the labour market are correlating with high levels of carers in work. Several countries have recognised the necessity of supporting professional services or measures to reconcile work and family life. These labour market policies are promoted strongly in Denmark and Sweden.

Member states should prioritise the integration of women into the labour market. This will not necessarily lower the costs of long term care but triggers a market driven policy process to introduce more measures to enable the reconciliation of work and long term care. At this point it is important to note that female carers with a long working biography and full time employment are more likely to stay on the labour market when taking on care obligations. Hence, policies should focus on full labour market integration of women.

Endogeneity in labour market participation of carers has to be considered. Many informal carers who take on care obligations were formerly unemployed or had low chances of entering the labour market or bad career prospects. Care is for them an alternative and not an addition to work which has to be reconciled.

Measures to improve labour market participation of carers which based their decision on unemployability could be general training programmes. Carers which career prospects are more willing to work and care than those without.

Flexible working arrangements are important to keep carers in touch with the labour market to ease re-employment once caring spells come to an end. Reconciliation measures such as part-time work at the one hand enable care and work (with reduced hours) which is better than not being able to work at all. On the other hand these measures have to be implemented carefully as the effects on the career prospects of women are ambiguous.

The introduction of flexible working time models is absolutely necessary to reconcile work and care. In addition to general part-time work rights the right to work reduced hours in times of special care needs should be implemented. Important is the combination with the right to return to full working hours after a caring spell ends. Germany introduced the general right to work part-time in companies with 15+ employees in 2001. In Austria, employees are entitled to work part-time for care reasons with the important right to increase hours when the caring spell ends since 1997.

A modularisation of professional care services simplifies the individual working arrangement. A choice should not be to decide between professional and informal home care. An individual combination of both should be possible. This in combination with flexible working time models would enable the carer to adjust the work - care arrangement according to their needs. Modularisation can be also encouraged by cash-payments to the care receiver. Most flexibility is achieved by “Personal or Individual Budgets”. The trend to individual budgets helps to create demand oriented services for persons in need for care. In addition it can help the informal carer as the use of timely flexible services should be possible.

The Netherlands introduced a “personal budget” for people with long-term care needs, thus adapting care services. The money can be spent according to the caree’s needs on different modularised services. This enables additional family carers a greater flexibility in their use of time as well. The Dutch evaluation of the scheme supports the importance of free choice but notes the increasing “monetisation” of family relations. Persons who were previously providing intra-family assistance are now asking for a financial payment. This raises the question of the distribution of caring tasks between social security and family.

Informal carers should be supported by information and counselling services. This should include care techniques, health aspects but also information on how to organise work and health.

Sweden stressed the importance of improving the infrastructure of services for family carers by setting up resource centres that offer training, counselling, support groups, respite care and other programs. These measures are similar to the Netherlands, which set up support centres for informal carers providing information, counselling, advice, practical training, self-help support groups, and other services for informal caregivers.

From our data has become apparent that reconciliation of work and long term care works best in Denmark, Sweden and Finland. These countries focus mainly on universal labour market participation. Care services are in the hands of the state and it is a societal agreement that these services have their price. To control costs the countries moved from high levels of institutionalisation to home care. Family care comprises rather minor tasks and low quantities of time. Heavy caring is still in the hands of professional services. As flexible working time models are already common (part-time work) reconciliation of work and care is easier than in many other countries. Other countries may focus on the cost control or assurance of care. However, this might be on the cost of reconciliation and in the end on the cost of labour market participation, especially of women.

Analysing the policies of the countries of our samples the following three different approaches can be identified. Policies focus on (a) labour market participation, (b) cost control of care or (c) securing the provision of care. The challenge is to find a sound mix between these three goals.

The assessment of policy proposals often focus on costs supported by public funds. Consequently, they arrive often at the conclusion that informal care is a less costly option compared to alternative solutions. Future assessments, ought to take into account the wage loss for the carer and notably the actual value of expected losses in terms of pension rights.

To summarise, we can note that the main recommendations include notably:

- Develop social services in order to meet the needs of care dependent people living in the community, notably those needs requiring heavy care;
- Promote flexible work arrangements enabling the carer to remain on the labour market;
- Promote consensual approaches and the involvement of social partners;
- Compensate for negative impacts on the long terms (notably through pension credits);
- Support family carers in order to reduce negative health impacts (including psychological health);
- Favour the establishment of ordinary work contracts through carer allowances and personal budgets;
- Recognition of the carer's role in the organisation of long term care at local level;
- Promote sharing family caring responsibilities more equally between women and men, notably by removing obstacles to men's use of long-term care benefits;
- Design measures assisting dependent people which are neutral in their labour market implications;
- Long-term care could be developed as a separate axe for insurance. Dependency may be seen as a separate risk. Public funds could bring a complement in order to guarantee a minimum quantity and quality of long-term care services to disadvantaged groups;
- Carers of disadvantaged groups ought to retain a special attention at local level.

Mediterranean countries and New Member States face a double challenge: developing infrastructures for the heavily dependent people and expanding home help. Only this double direction policy may liberate informal carers from heavy long term care which keeps women in a disadvantaging situation.

Generally, the different measures ought to improve the quality of services provided to dependent people and improve the work life balance of carers.

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PART II: Statistical analysis

DATA SOURCES

The statistical analysis is based on four sources of data:

- the special ad hoc module of the EU Labour Force Survey (LFS) on people with disabilities and long term health problems – carried out in 2002;
- the data collection of the EU Statistics on Incomes and Living Conditions (EU-SILC) carried out in 2004 and 2005;
- the ECHP UDB (notably Wave 8, 2001), and
- SHARE first wave, release 2, 2004.

The data concerning the LFS, the EU-SILC and the ECHP UDB were provided by the European Commission (Eurostat).

Country coverage of the surveys differs somewhat:

- the LFS covers all EU Member States except Latvia, Poland and Bulgaria and includes Norway;
- the EU-SILC covers EU Member States (except Malta) and also Iceland and Norway. However, the 2004 survey covers only 13 Member States – EU15 except Germany, the Netherlands and the United Kingdom, plus Estonia and also includes Norway;
- the ECHP UDB covers EU 15, and
- SHARE covers Belgium, France, Austria, The Netherlands, Spain, Italy, Sweden, Germany, Greece, Switzerland, Israel and Denmark.

The age of the sample varies according to the survey:

- The LFS Ad hoc module 2002 covers people from 16 to 64;
- The EU SILC and the ECHP UDB cover people from 16 and over;
- The SHARE covers people aged 50 and over.

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1.1 Health and age management

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PART IV: Recommendations concerning promising policies that may be transferable across Member States

1. Health and labour market participation

1.1. Health and age management

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2. Financial (dis) incentives

3. Active ageing

3.1. Activity and health

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